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ABSTRACT

This volume of 12 lessons--each one written by either a medical or a mental health professional--provides expert information on a variety of medical and psychological issues in rehabilitative counseling. The lessons, each of which concludes with a few multiple-choice questions, are as follows: (1) "An Update on Post-Traumatic Stress Disorder" (Marion E. Wolf and Giselle S. Mosnaim); (2) "Dealing with Difficult Clients" (George A. Harris); (3) "Child Abuse, Sexual Abuse, and Neglect" (Penelope Krener); (4) "The Understanding and Management of Chronic Pain" (David W. Swanson); (5) "Vocational Rehabilitation in Traumatic Brain Injury" (Robert T. Fraser); (6) "Resistance to and Fear of Change" (James F. T. Bugental and Elizabeth K. Bugental); (7) "Hope" (W. W. Meissner); (8) "The Management and Resolution of Dependency in the Depressed Client" (John A. Birtchnell); (9) "Professional Ethics for the Rehabilitation Counselor" (Daniel F. Crawford); (10) "Techniques Designed to Energize Clients Toward Self-Help" (William G. Emener); (11) "The Effective Use of Vocational Evaluation Services" (Stephen W. Thomas); and (12) "Supported Employment: An Overview for Rehabilitation Counselors" (James Schaller, Edna Mora Szymanski, and Cheryl Hanley-Maxwell). (Contains an index. Each lesson contains references.) (RJM)

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Directions in
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VOLUME 2 • LESSON 1

An Update on Post-Traumatic Stress Disorder

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EDITOR'S NOTE

Post-traumatic stress disorder is a diagnosis which most counselors automatically associate with combat duty, soldiers adversely affected by war experiences, or other dramatic kinds of stress, such as airplane accidents. In fact, one can adhere to the strict definition of the disorder, i.e. that it follows a psychologically distressing event that is outside the range of *usual* human experience, and still find it occurring among many clients seen in everyday practice: near drowning, automobile accidents, and the like. I have made a point of asking all clients I see in consultation whether or not they have had any such experiences; on a number of occasions they have, and not uncommonly the emotional disruption triggered by these events has not been adequately recognized, dealt with, and resolved. A kind of psychological numbing, or inexplicable episodes of anxiety, or periods of occupational or interpersonal dysfunction can be traced to such times in a client's life, setting off a series of conditions that may lead to severe depression or other psychopathological states.

Clients with PTSD may reexperience, in dreams or when exposed to things that remind them of the stressful event, the fear and helplessness that they felt at the time. Some engage in massive avoidance of stimuli that would bring the memory to mind. Many experience a generalized numbing, as I have seen, or its opposite, a state of increased arousal and hyperreactivity.

PTSD may start a few hours or days after the traumatic occurrence or, in its delayed form, months or even years later. An inexplicable sense of a shortened future life, difficulty falling or staying asleep, irritability, and concentration problems are common.

In this lesson, the authors explore some of the hypotheses that have been suggested to explain the nature of PTSD, including the vulnerability hypothesis, which holds that after such a distressful event, coping mechanisms are compromised and future stress produces even more catastrophic physical and emotional illness, and my own resilience hypothesis, which holds that disruption is the inevitable consequence of stress of all kinds, setting the stage for reintegration to a new and higher, more complex level of adaptation.

In the acute form of PTSD, treatment follows the crisis intervention model, where the goal is to restore the traumatized person to a pre-trauma level of functioning as quickly as possible, using ventilation of feelings and support systems effectively. Chronic or delayed forms of PTSD are more complex and call for the use of a wide array of psychotherapeutic and psychopharmacologic approaches; here the outcome can be adversely influenced by factors that encourage disability rather than health, such as financial compensation for injury or environments that do not attend to the restoration of resilience and the will to be well.

Introduction

The adverse psychological effects of combat have been recognized since the Civil War, when they were generally regarded as transient anxiety reactions. After World War II intense attention focused on postwar syndromes, with special clinical interest in combat-induced stress reactions. As a result of those studies, the diagnostic category "gross stress reaction" was included in DSM-I.[1] Following the war in Vietnam, many veterans of that conflict exhibited a complex mixture of psychiatric symptoms related to their combat experience. Post-traumatic stress disorder (PTSD) was formalized in 1980 with the establishment of explicit diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III).[2]

Definition

Post-traumatic stress disorder is described in the *Diagnostic and Statistical Manual of Mental Disorders,* third edition, revised (DSM-III-R)[3] as follows:

> **The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict). The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness. The characteristic symptoms involve reexperiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased arousal.**

The Clinical Picture

The central features of PTSD[4] are composed of symptom clusters that include hyperreactivity with excessive autonomic system arousal, such as startle reaction, hyperalertness, or hypervigilance. Also, reexperiencing the trauma in distressing intrusive images, nightmares, and dissociative states is common. The person attempts to ward off hyperreactivity and the reexperiencing of the traumatic event with psychic numbing, constriction of affect, loss of emotional responsiveness, and decreased involvement in work and interpersonal relationships.

The disorder may begin a few hours or days after the traumatic event or months or years after the stressing event. Acute, chronic, and delayed-onset types of PTSD have been described.

DSM-III-R Criteria:

The diagnostic criteria for PTSD, according to DSM-III-R, are:

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

  1. Recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed).

2. Recurrent distressing dreams of the event.

3. Sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated).

4. **Intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma.**

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts or feelings associated with the trauma.

2. Efforts to avoid activities or situations that arouse recollections of the trauma.

3. **Inability to recall an important aspect of the trauma (psychogenic amnesia).**

4. Markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills).

5. **Feeling of detachment or estrangement from others.**

6. Restricted range of affect, e.g., unable to have loving feelings.

7. **Sense of a foreshortened future,** e.g., does not expect to have a career, marriage, children, or a long life.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

1. **Difficulty falling or staying asleep.**

2. **Irritability or outbursts of anger.**
3. **Difficulty concentrating.**
4. **Hypervigilance**.
5. **Exaggerated startle response.**
6. **Physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event** (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator).

E. **Duration of the disturbance (symptoms in B, C and D) of at least one month.**

Psychosocial Framework of PTSD

Lyndy, Grace, and Green[5] have formulated a psychosocial model for the natural history of PTSD. They suggest traumatic stress, individual characteristics, and environmental factors interplay in various fashions in the development of PTSD. Stressors may be natural disasters (earthquakes, floods), accidental disasters (motor vehicle accidents, airplane crashes), or created disasters (death camps, torture, bombing).

A variety of individual characteristics, such as early childhood experiences, preexisting psychopathology, and coping mechanisms, affect a person's tendency to develop psychological sequelae to trauma. Environmental factors such as **availability of social supports** may also influence the development, severity, and duration of PTSD. In general, individuals who have a good network of social support are less likely to develop PTSD, whereas those who are economically or socially deprived are more vulnerable.

When the intensity of the trauma is manageable and personality strengths and environmental resources are sufficient, the trauma is worked through and the stress reaction is limited. However, when the coping mechanisms are inadequate and the person is continually overwhelmed by intrusive phenomena alternating with avoidance mechanisms, ne or she may experience psychic overload and develop PTSD.

Reactivation of a Stress Disorder

Reactivation of a stress disorder may occur following any of a variety of stressful events. Several hypotheses have been formulated on the effects of repeated exposure to stress.[6]

The Vulnerability Hypothesis:

The vulnerability hypothesis proposes that with each stressful event, the number of coping mechanisms that are available decreases, thus increasing vulnerability to physical and emotional illness.

The Stress Inoculation Hypothesis:

The stress inoculation hypothesis holds that repeated stress may affect health positively by rendering immunity to future traumatic experiences. Each stressful event of a similar nature would increase familiarity, lead to a decrease in the severity of the perceived stress, and result in more successful coping.

The Stress Resolution Hypothesis:

The stress resolution hypothesis holds the important factor is not exposure to stress, per se, but the outcome of earlier stressful experiences. Successful handling of a stressful event would lead to ego growth through crisis resolution, a sense of mastery, and feelings of well being as well as help in developing positive expectations about encounters with future adversities. On the other hand, if the outcome of exposure to a stressful situation is unsuccessful, it may lead to decreased self-esteem, increased distress, and doubt about future success in coping when faced with similar stress. All are factors that increase vulnerability to medical or emotional disturbance. Solomon et al.[6] studied Israeli solders who, given the particular historical-political situation in their country, are exposed to repeated stress of battle. The stress resolution hypothesis, they conclude, predominates in their findings.

The Resilience Hypothesis and PTSD

A different approach to the conceptualization of PTSD within the framework of the resilience hypothesis has been proposed by Flach.[7] He defines psychobiological resilience as "the efficient blending of psychological, biological and environmental elements that permit human beings to successfully transit episodes of chaos necessarily associated with significant periods of stress and change." According to that theory, human beings who encounter severe trauma should be expected to be emotionally disrupted by the distressing event. The key to mental health or illness lies in "a) how the phase of disruption is managed by the individual and b) how able he is to recover spontaneously from the disruptive phase of the stress response to establish new, higher, more complex and more adequate levels of homeostasis afterwards."[7]

Thus, Flach suggests an important question in assessing clients with PTSD is: Why have they been unable to reintegrate successfully, with or without professional help? It is important to understand the particular meaning that the traumatic event holds for the client and to stimulate his or her will to be well. That latter approach not only includes an active effort to encourage clients to create future goals and motivate them to strive toward those goals, but they may also need to reduce environmental influences that may interfere with the will to recover.[7] Strong forces can encourage disability. The secondary gain derived from receiving caring attention, the financial compensation that accompanies disability, and avoidance of engaging in life with all its opportunities and risks is detrimental to recovery.

Prognosis

According to DSM-III, PTSD may be acute, chronic, or delayed.[2] A diagnosis of acute PTSD is based on the onset of symptoms within six months of the trauma and duration of symptoms of less than six months. A duration of PTSD symptoms of six months or more characterizes chronic PTSD, whereas the onset of symptoms at least six months after the trauma characterizes delayed onset PTSD. (Reactivated PTSD was examined earlier in this lesson.)

Acute PTSD has a much better prognosis than chronic or delayed onset PTSD, tending to confirm Flach's resilience hypothesis. In many cases, its symptoms resolve spontaneously without counseling intervention. Chronic and delayed-onset PTSD are less common, are associated with greater impairment and disability and

have a less-promising prognosis. Recent studies by De Loos[9] suggest that **in addition to the features of acute PTSD previously described, chronic and delayed forms are characterized by a variety of somatic conditions such as somatoform disorders, which often have a symbolic value related to the traumatic experience; vegetative and psychomotor expressions of anxiety, which can take the form of exhaustion; and organic disease, especially classic psychosomatic ailments.**[9] Clients with chronic PTSD often display interactions between behavioral and organic factors, including somatoform aggravation, negation of disease, abuse of or dependence on medications, and diagnostic problems with inherent therapeutic consequences.[9,10]

The overall clinical picture of chronic or delayed-onset PTSD includes a decrease in personality functioning that interferes with family life, work, and social and recreational activities. Depression and guilt may lead to suicide attempts, and poor impulse control may trigger incidences of violence and result in legal difficulties. **Concomitant substance abuse disorders are frequent complications** of the chronic and delayed-onset forms of PTSD. Such substance abuse can also lead to aggression and legal difficulties.

Differential Diagnosis

Given the varied, nonspecific manifestations of PTSD described in DSM-III-R and the problems of comorbidity of PTSD with personality disorders, substance abuse, and other conditions, **the process of diagnosing PTSD is complex. Issues of sham, as opposed to genuine, PTSD also need to be addressed,** and **the importance of obtaining a carefully detailed history** cannot be sufficiently underscored. Factitious disorder, malingering, adjustment reactions, depression, chronic pain disorder, head injury, generalized anxiety disorder, mood disorder, panic disorder, alcohol and drug dependence, and schizophrenia are some of the conditions to be considered in the differential diagnosis. A careful history, together with a thorough work-up for organic pathology, may provide the basis for an accurate PTSD diagnosis.

Management of PTSD

Management of stress reactions after trauma in the acute phase follows a crisis intervention model, with a goal of restoring the traumatized individual to a pretrauma level of functioning as quickly as possible. In the military setting, the principles of immediacy, proximity, and expectancy in the treatment of acute PTSD are important for a favorable outcome.[11]

Management of chronic or delayed-onset PTSD is complex, and a variety of therapeutic interventions have been employed, including psychoanalysis, insight-oriented psychotherapies, forms of group and family therapies, stress management techniques, and multiple behavioral approaches such as imaginal flooding and implosive therapy, systematic desensitization, and various pharmacotherapies. Different combinations of those forms of treatment have been used in both inpatient and outpatient settings.[12]

Counseling in PTSD

Embry[13] identifies seven parameters for effective counseling of PTSD clients, particularly Vietnam veterans.

Rapport Building:

Establishing rapport with Vietnam veterans suffering from PTSD, who are often mistrustful of the "system" and specific individuals, requires considerable time and effort. It is important to understand the meaning of the traumatic experience for the individual and the defense mechanism he uses against perceived stress.

Limit-Setting with Supportive Confrontation:

Limit-setting is often an issue throughout treatment because clients often test their counselors to determine the constancy of their responses. The client must clearly understand the ground rules for counseling from the very beginning.

Affective Modeling:

PTSD clients present with psychic numbing, so **they need to regain contact with a variety of emotions in counseling**. The counselor has "to help the [client] to unlearn the 'tough masculinity' of his military experience, and actually give him 'permission' to feel."[13]

Defocusing on Stress:

Many clients will devote their counseling sessions to verbalizations of their traumatic experiences. From time to time, defocusing on stress issues and emphasizing the here, now, and future is necessary. That may enable the client to learn ways of minimizing anxiety-provoking stimuli at the same time it provides an opportunity for dealing with the individual's ongoing problems.

Transference-Countertransference Issues:

As in any counseling situation, issues of transference and countertransference need to be confronted. **The counselor who works with Vietnam veterans with PTSD is set up for rejection from the beginning, given the fact that many of those clients have significant difficulties with authority figures.** The counselor and client must work together in a collaborative effort to deal with those issues.

Understanding Secondary Gain:

Vietnam veterans with PTSD have a sense of entitlement to monetary remuneration under the label of service-connected compensation or to an increase in eligibility through care status. This "quest for entitlement through what veterans call 'the maze of red tape' may take extreme proportions."[13] **Clients may feel a need to remain sick because if they improve and are willing to return to work, they may lose their benefits but be unable to earn a living.**

As noted previously, Flach has discussed the need to reduce environmental influences that may interfere with a client's will to recover and the strong forces that encourage disability while building an attitude of realistic hope.[7]

Positive Counseling Attitude:

The counselor must convey to the client his/her own belief that he/she can help the client to adjust and improve his life following trauma. The combination of a positive therapeutic attitude in the counselor in spite of the PTSD client's testing and impulsive behavior and the client's will to get better constitutes basic terms for effective counseling.

Pharmacological Intervention in PTSD

As previously stated, the management of chronic or delayed-onset PTSD is complex and involves the use of multiple therapeutic approaches, including psychosocial and pharmacologic interventions. Recent advances in the pharmacotherapy of PTSD have been helpful in the symptomatic relief of many PTSD manifestations and have made clients more amenable to other treatment modalities.

Given the hypothesis that PTSD involves an abnormal arousal of the central adrenergic system, Kolb and associates recommend the use of **beta-adrenergic receptor blockers such as propranolol (Inderal).**[14] In view of the frequency of depression-related symptoms in PTSD, several investigators have advocated the use of **tricyclic antidepressants.**[15-18] **Monoamine oxidase inhibitors (MAOIs)** have also been thought useful, particularly in the management of PTSD clients with such atypical depressive features as phobias, hypochondriacal complaints, anxiety, and hypersomnolence as well as for those with severe nightmares and flashbacks.[19,20]

Kitchner and Greenstein report beneficial effects of **lithium** in Vietnam veterans with PTSD and support the use of that drug in the treatment of PTSD based on lithium's reported usefulness **in the treatment of clients who are prone to aggressive acting-out.**[21] Reports by Lipper and colleagues[8] and Wolf and coworkers[22] suggest **carbamazepine (Tegretol)** may also be helpful in the treatment of PTSD.

Other psychotropic drugs such as neuroleptics, anxiolytics, and hypnotics have also been used in the treatment of PTSD.[23,24] **Neuroleptic use is restricted, however, given the risk of tardive dyskinesia. Many clients with PTSD have prominent depressive**

symptoms, and Wolf and associates report that subjects with affective disorders are more vulnerable to tardive dyskinesia.[25] **The use of anxiolytics and hypnotics risks development of addiction,** and, given the high frequency of comorbidity of PTSD with substance-abuse disorders, prescribing such potentially addictive drugs for PTSD should be thoroughly analyzed.[26,27]

To summarize, then, **the clinical picture of PTSD may include symptom clusters related to anxiety, depression, or poor impulse control. Those symptoms would appear to respond preferentially to beta blockers, antidepressants, and carbamazepine, respectively.** Additional studies using a double-blind design and quantitative clinical assessments, as well as electrophysiological and biological measurements, are needed to critically evaluate the effects of various pharmacological agents in PTSD.

Controversial Issues in PTSD

The introduction of PTSD as a diagnostic entity in DSM-III has fostered studies on the biological and clinical characterizations of the disorder. **Along with rising interest in the syndrome, doubts regarding the diagnostic validity of PTSD continue to be expressed.** A diagnosis of PTSD is based primarily on subjective symptoms rather than observable signs. Also, given the varied and nonspecific manifestations of PTSD, **it has been argued that clients with the condition could be classified into other DSM-III diagnostic categories. Furthermore, given the high frequency of Axis I and Axis II codiagnoses in those with PTSD--particularly depression, anxiety, substance abuse, and personality disorders--a differential diagnosis is complex. Additional** complications arise from factitious symptomatology, socioeconomic factors, and the malingering associated with compensation claims.

In view of the controversial diagnostic issues in PTSD, the interpretation of biological findings in this condition as well as the specificity of response to pharmacological agents–that is, whether positive therapeutic actions of various drugs represent symptomatic relief of depression, anxiety or poor impulse control, as opposed to "specific anti-PTSD effects"–require a critical analysis.

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QUESTIONS BASED ON THIS LESSON

1. Which of the following statements about PTSD is/are correct?

A. Chronic or delayed PTSD have a much better prognosis than acute PTSD

B. Somatoform disorders, which often have symbolic value related to the traumatic experience, are common in acute PTSD but are never seen in the chronic or delayed form

C. Chronic or delayed-onset PTSD often includes a decrease in overall personal functioning, with depression, suicidal ideas and attempts, and poor impulse control

D. Rarely, if ever, does PTSD coexist with other diagnostic categories described in DSM-III-R.

2. The resilience hypothesis proposes that:

A. With each stressful event, the number of coping mechanisms always decreases, thus increasing vulnerability to physical and emotional illness

B. Repeated stress leads to immunity to all future traumatic experiences

C. Stress poorly-handled increases ego strength, whereas that well handled decreases self-esteem and reduces resources to deal with future stress

D. Human beings encountering severe stress must become emotionally disrupted, and the key to health is how the disruption is managed and the person's ability to reintegrate at a new, higher, more complex and competent level of function afterwards

3. Which of the following elements is/are important in carrying out counseling with PTSD clients?

A. Affective modeling, particularly in patients with psychic numbing

B. Defocusing away from the traumatic experience

C. Understanding and resolving secondary gain

D. All of the above

over, please...

4. Post-traumatic stress disorder:

A. Is characterized by symptoms that involve reexperiencing the traumatic event, as in dreams or anniversary reactions

B. Is triggered by ordinary stressful events, such as business disappointment or occasional marital conflict

C. Is triggered by unique stresses that most people would not react to unduly with any fear or helplessness

D. Never involves avoidance of stimuli associated with the event or numbing of general responsiveness

Directions in Rehabilitation Counseling

VOLUME 2 • LESSON 2

Dealing with Difficult Clients

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Directions in Rehabilitation Counseling
VOLUME 2
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EDITOR'S NOTE

In this lesson, the author reviews the elements that go into client resistance. Resistance may stem from fear of change. Or it may be rooted in difficulties in accepting either the counseling process or the professional doing the counseling. The problem is considerably more pronounced when the client has been coerced into participating in counseling, as in the case of prisoners or substance and alcohol abusers.

Clients may resist counseling because it can be costly and inconvenient to them. The most important psychological source of resistance are mistrust or cynicism about the value of talk in solving problems, the sense that freedom is compromised by the counseling process, and the client's belief that his or her problems are largely, if not exclusively, external to self.

How the counselor reacts to a client's hostile, uncooperative, or rebellious behavior will clearly influence the level of compliance that ultimately can be achieved. It is often essential to develop rapport and some level of trust before approaching the resolution of clients' problems. Among the specific approaches mentioned are emotive strategies, cognitive therapy, and paradoxical methods. Periodic case review with a colleague-consultant can often help, particularly when a client is difficult or adequate progress is not being made.

Introduction

Every counselor encounters clients who are difficult, although what one counselor finds difficult another may not. The counseling literature is replete with discussion of "resistance," but as Anderson and Stewart stated, resistance is often defined as whatever clients do that counselors don't want them to do.[1]

Despite disagreements in defining difficult clients and in resistance, it is possible to **identify some common causes of problems in treatment.** Those causes can be observed by looking at **resistance to change**, to **the counselor**, and to **counseling itself**. This lesson will also discuss: **counselors' reactions to clients that may impede treatment; client accessibility to treatment; general approaches to working with difficult clients; and points to consider when counseling difficult clients.**

Resistance to Change

Most theories of counseling have an explanation of resistance to change. **Behaviorists identify the cause of resistance as inadequate reinforcement; family therapists see resistance as a function of the system's efforts to maintain homeostasis and keep the status quo; rational-emotive therapists view resistance as the product of irrational beliefs; psychodynamic theories hold the unconscious prevents awareness of material that would cause psychic distress.**

It is important not to view all resistance as bad. Ellis[2] pointed our **clients may resist therapists' suggestions because the suggestions are just wrong.** Ansbacher[3] argued **resistance can be a necessary result of stability and integrity of personality:** after all, if a person never resisted change, he or she would never settle on a career, a spouse, or even an opinion. **The counselor's job is not to remove resistance to change, but only those resistances that are dysfunctional for the client.**

Resistance to the Counselor

Many theories of psychotherapy consider transference issues appropriate for the counseling process. During the course of counseling, the client may have a reaction to the counselor that seems to be based on imagined rather than actual truths about the relationship that has developed. The client confuses the counselor with someone else–often a parent or authority figure, sometimes a sibling, or occasionally someone who just looks like the counselor. Understanding those reactions is an important tool for helping the client learn to deal with people objectively rather than as mirages and reminders of past unrelated encounters.

Transference issues are especially important when working with clients who have been *coerced* into counseling. Such clients come from correctional, substance abuse, and many other rehabilitation programs. Meloy and associates wrote the involuntary client has special transference issues because the therapeutic encounter mirrors the early parent/child relationship, which was biologically an involuntary one for the client.[4] Most therapists overlook or minimize the problem of involuntariness in counseling.[5] In their zeal to begin talking about the client's "problem," counselors may not spend enough time dealing with the resistance to the counselor that is created by the mere fact that counseling was required, not chosen. As a result, the client's view of the counselor as an agent of coercion is never challenged.

Resistance to Counseling

Most counseling theories assume the counseling relationship is voluntary and treatment can not be initiated ethically until permission to counsel is granted.[6] In reality, thousands of clients every day are counseled without consent in prisons, drug programs, and even in private practice. Thus, it is useful to consider resistance to counseling as separate from resistance to change and to the counselor.

Many behavior problems and psychological disorders, such as substance abuse, are accompanied by **intense denial**, and clients with such problems and disorders do not seek treatment until they are forced. **Even in marriage counseling, it is common for one spouse to be eager for counseling while the other resists.** The counselor may wish to differentiate "counseling" from "preparing the client for counseling," as a way out of an ethical quagmire. In a sense, the client needs to be sold on the value of counseling. **He or she needs to be convinced that counseling can help in some way.** It is not unethical to help clients discuss their feelings, objections, and concerns about being coerced into treatment. Such discussion is the beginning of the formation of a therapeutic relationship, though the specific reason why the client was referred may hardly be mentioned. **After thoroughly exploring the issues related to participation in counseling, *either counselor or client* may elect not to continue.**

Most theories of counseling have an explanation of resistance to change and resistance to the counselor, some in more detail than others. However, few theories directly address or give recommendations for resolving the resistance to counseling per se that may clients demonstrate. Therefore, it may be helpful to explore our understanding of why clients object to counseling.

Why do clients resist counseling? There are may practical reasons, including **expense** and **inconvenience**. Other reasons are related to the **resistance to change**. Attending counseling represents change, which the client fears. **There are three primary reasons why clients resist entering treatment:** 1) **Mistrust or cynicism about the value of talk in solving problems,** 2) **the psychological reaction to a perceived loss of freedom,** and 3) **the client's belief that the problem is external to self** and therefore cannot be solved by personal initiative.

Mistrust:

Mistrust of counseling and counselors is understandable when it is considered **how often people feel that they have been deceived by promises from authority in**

their lives. That feeling of having been misled leads to cynicism, pessimism, and, therefore, reluctance to participate in counseling. They just don't believe counseling can be trusted. **Many clients mistrust themselves and their own capacity to change.** They've told themselves before they would change and didn't, so they don't understand how counseling could help. Thus, not only people but language itself is doubted. Counseling is dismissed as only talk, and "talk is cheap."

Loss of Freedom:

The second reason clients resist counseling is they **object to any kind of coercion and restriction of freedom.**[7] **Counseling must be portrayed as an opportunity to increase freedom** by pointing out that the process is designed not to restrict but to increase alternatives. That may be **difficult for clients to see in the abstract,** but counselors can try to make the point. Most important, counselors can **try to give clients as many choices as possible in appointment time, topics to discuss, and even seating arrangements.** Such attention to choices demonstrates rather than merely describes the nonrestrictive nature of the process.

Externality of the Problem:

The final major cause of resistance to counseling is the client's belief that his or her problems are external to self. After all, **if the problems are the fault of parents, schools, spouses, or society in general, why would clients think anything they could change would make a difference?** Clients often say, "You've got the wrong person in here. You should fix ________."

Of course, **it is often difficult to convince people of their responsibility for their own dilemma.** Most counseling theories assume not only a voluntary relationship between counselor and client but also the client's perception of personal responsibility for the problem. **Such personal responsibility would be accompanied by anxiety or**

guilt, whereas externalizing responsibility is accompanied by anger or blame. The latter are emotions less likely to evoke sympathy in counselors and more likely to elicit rejection and distancing from the client, which clearly makes treatment more difficult.

Counselor Reactiveness to Difficult Clients

When clients react negatively, the counselor's response will, of course, affect the progress of treatment. There are several frequent and understandable counselor responses or countertransference reactions.

It must be expected that **clients who view counselors as authority or parent figures and act rebelliously will sometimes elicit authoritarian, critical parentlike behavior from counselors. It is often hard not to have punishing or rejecting feelings toward clients who act out their dislike of authority, *even when one consciously knows why such behavior occurs.*** Many clients devalue and disparage counselors' efforts to be helpful, and that may cause counselors to feel rage and rejection.[4]

When clients are violent or intimidating, many counselors understandably feel threatened and afraid, emotions that both inhibit the desire to help and/or confront and arouse basic defenses. Those defenses typically manifest in fight-or-flight behavior, but some counselors may feel frozen, numb, or paralyzed in the face of physical threat.

Just as clients often harbor mistrust of words (and therefore counseling), as a result of prior broken promises in life, so too may counselors. **Counselors who are deceived or misled by resistant clients may experience an arousal of feelings that range from anger to disgust, and that may recreate feelings from their own earlier life experiences.**[4] When counselors work frequently with clients who lie or deceive, they may develop cynical attitudes that are apparent to all clients and sabotage the counseling process. **That becomes a self-fulfilling prophecy, as counselors anticipate being deceived and, not wanting to appear gullible, approach all clients as potential liars.** Clients in turn oblige the expectation because they are predisposed not to believe in the possibility of an accepting, honest relationship. And so it goes. **The end result of this cycle is therapeutic nihilism,**[4] a counselor's cynical doubt that counseling can be effective with certain groups of people.

Some counselors doubt that anyone will honestly participate in a change process. Often, counselors believe everyone will. **Therapists may overrate the development of the treatment alliance and progress with clients who in reality are going nowhere.**[4] Although it is difficult to be critical of anyone who is optimistic, the term hopeless optimist does suggest that **optimism should be tempered with realism** if for no other reason than the possible wasting of valuable resources on people who are not being helped.

Counselors often misunderstand clients by assuming they share experiences, feelings, and values.[4] **That is an especially important problem when working with anti-social clients,** who may deliberately lead the counselor into giving rosy assessments of therapeutic progress. Such assessments may be advantageous to clients who are trying to achieve early release from treatment. **Therapists need to be particularly alert to clients who display guilt and remorse when none exist.** It is hard for many therapists to comprehend that some clients do not truly experience normal guilt.

It is probably impossible for counselors not to be either a little too pessimistic or optimistic at the beginning of treatment. We all have our own personalities and world views and cannot be totally objective. **Perhaps the most dangerous effect of the counselor's personality on the client is the unconscious encouragement of acting out, rebellion, or misbehavior. Some counselors unfortunately gain vicarious satisfaction from their clients' sexual encounters or flouting of authority.** Clients who are already predisposed to inappropriate behavior are easily encouraged when therapists grin at tales of escapades or encourage accounts of binges or lost weekends. **Counselors should seek consultation if their clients seem to get consistently worse rather than better in treatment while the counseling sessions seem to be friendly and productive.**

In summary, not all client resistance comes strictly from within the client. The counselor's reactions to the client's behavior may exacerbate the problem. Some therapists are cynical toward clients, and their attitudes discourage treatment relationships; and sometimes the counselor may unconsciously desire the client to misbehave. That is iatrogenic (treatment-induced) resistance. The reactions of therapists to provocation and intimidation may impede treatment by blocking their desire to help or confront.

Counseling Approaches to the Difficult Client

Not everyone can agree on one counseling theory, and the disagreement compounds when the client is difficult. Nevertheless, it is possible to categorize several different general approaches and discuss the pros and cons of each.

Emotive Approaches:

Most counselors are familiar with what are called emotive approaches. They are **counseling styles aimed at reflecting the client's feelings and cognitions to encourage exploration and self-examination but also to develop the relationship between counselor and client.** Therapists, from person-centered counselors to psychoanalysts, may use **active listening techniques** to achieve these goals. Weiss[8] described recent research on unconscious functioning from a psychodynamic perspective in which resistance is seen not merely as an unconscious act to block awareness of painful material but rather as **an unconscious act to block interpersonal disclosure until the person feels safe.** That research has profound implications for psychotherapy in underscoring the importance of accepting, nonjudgmental relationships for therapeutic progress.

It is important when working with difficult clients to **avoid focusing too quickly on the problem that triggered the referral. Many counselors are eager to begin problem solving and do not allow time for clients to explore their feelings about being in therapy and, if such be the case, about having been coerced into treatment.** Given the understandable fear of many clients about being direct and open about their feelings, it becomes all the more important to **build relationships** and **develop trust**. As Weiss pointed out, the resistance may be unconscious, but the client may be well aware of the reluctance to participate.[8] In either case, when the counselor pushes too rapidly into the reason for referral, important opportunities to establish a cooperative relationship are lost.

Cognitive Therapy:

A second general category or approach is cognitive therapy. **With difficult clients, cognitive therapists may elect to challenge clients' beliefs that inhibit participation in counseling and cooperation** with the counselor. For example, some involuntary clients may resist participating in treatment because they believe they should get to do what they want to do when they want to do it or that they shouldn't have to do what they don't want to do. Rational, emotive therapists often attack such statements with logic and evidence. Such confrontation, however, may arouse defensiveness. Ellis, in advocating forceful persuasion, acknowledged **persuasion is called for when the client resists change but relationship building is essential when the client resists the counselor.**[2]

Cognitive therapies have been described as being of two major types.[9] **One deals with surface change of irrational thoughts and beliefs; the other deals with deeper change of personal constructs and patterns of belief.** Change of personal constructs is not easily amenable to argumentation and syllogistic reasoning; rather, it requires reflection and affective expression to facilitate cognitive restructuring. When clients have deep-seated characterological difficulties, it seems unlikely they will be able to examine their core difficulties without first developing some confidence and trust in a therapeutic ally. Again, that underscores the importance of relationship building.

Strategic or Paradoxical Approach:

A third general kind of approach for working with difficult clients is the strategic or paradoxical approach. Even though it is beyond the scope of this lesson to give a full explanation of any approach, paradoxical approaches are especially difficult to summarize.

When clients are defiant, paradoxical interventions can create cognitive binds that leave no opportunity for nonchange. **For example, when a client who does not trust the counselor is told that such mistrust is understandable, confusion results: the client hears a trustworthy statement from someone he or she did not expect to trust. The counselor might even direct the client to act cautiously based on the mistrust. A defiant client then becomes "compliant" by following the counselor's directive. Such paradoxical directives must be used cautiously**, however. Unfortunately, it is tempting to use them as manipulative gimmicks rather than as carefully thought-out strategies for helping the person.

Other paradoxical strategies involve the use of exaggeration to reshape the client's perception. For example, a client who admits to not trusting the counselor might be asked if he or she mistrusts everything about the counselor totally. Few clients will admit they truly believe the counselor to be a spy for the FBI, and some lighthearted teasing about this may help establish that trust and mistrust are on a continuum. It then becomes easier to explore degrees of trust and mistrust and ways to improve the relationship. Of course, if clients do think the counselor is a spy from the

FBI, it might be wise to consider a psychiatric consultation.

Another paradoxical strategy involves examination of positive intent behind negative behavior. Earlier when discussing resistance, I contended that resistance must be seen as a necessary component of stability and integrity in the personality. People do what they do for reasons they think are appropriate or, at least, justified. **For example, parents who are harsh with their children may feel that harshness to be justified in order to teach their children correct behavior. The parents' intent is positive, although the effects of the behavior may not be.** Counselors who can identify positive intent and acknowledge understanding of it to the client may arouse less defensiveness from the client. That in turn may **allow the client to explore the effectiveness of the behavior in achieving the desired goal.** Often, when people feel personally criticized, they defend themselves by attacking their attacker.

Finally, **paradoxical strategies acknowledge the great ambivalence that lies behind any significant change. A person with an alcohol problem, for example, has many reasons to quit** drinking, including health, expense, job security, and family relationships. **Still, there are also many reasons not to quit**, such as loss of drinking companions and facing personal problems when sober and not anesthetized. A counselor who simply confronts the client with all the reasons to quit drinking will meet with great resistance because the reasons to continue drinking are still operative. Paradoxically, **when the counselor can empathize with the client's ambivalence to change, the client is freer to fully explore both sides of the issue and take responsibility for the decision,** whatever it may be.

Stages of Accessibility with Difficult Clients

The fact that clients are sometimes not ready for counseling needs to be recognized. As discussed earlier, when involuntary clients resist the very idea of counseling, the counselor must spend time trying to "sell" the client on the process. Menninger described all psychotherapy with this sales metaphor and contended that even voluntary patients must agree to terms with the therapist before therapy can proceed.[10]

Therapy, especially in institutional contexts, proceeds in stages.[11] In the first stage, there is a struggle for control, which may often be passive and covert. The therapist is often tempted to become either autocratic or permissive. Neither approach is effective. It is important to **establish boundaries and expectations without becoming punitive** toward the client.

In the next stage of therapy, the client may express overt rebellion by refusing to come to sessions or to participate in sessions. When that occurs, the counselor is well advised to **let the natural consequences of nonparticipation take their course rather than becoming too personally invested** in involving the client. For example, when a probationer does not come to therapy, the counselor may advise the probation officer and then let whatever happens happen. If the benefits of counseling have been explained, then clients can deal with their decisions without exhortations from therapists.

Often clients must get sick and tired of being sick and tired before they acknowledge the need for treatment. Alcoholism counselors refer to this as hitting the bottom or gutter. It is often hard to watch clients do avoidable damage to themselves, but rescuing clients who don't want help is a form of co-dependency.

After clients have run into the wall enough times, they may finally return to the therapist and ask for help. A sincere request for help makes it much easier to establish mutually agreed-upon goals for treatment.

Points to Consider Regarding Treatment

The following points may be helpful in guiding the counseling process.

1. Counselors have to **establish an environment in which communica-**

tion can occur by looking at factors that facilitate and inhibit communication. Clients will not talk if they feel threatened and most are more likely to talk if they sense the counselor's understanding.

2. **The client's problem must be identified. What needs changing? What does the client think needs changing, if anything? What is blocking the change?** Are there reasons why adapting would not be in the client's interest? Do the client's underlying character and values block normal relationships, or is the person capable of being influenced by feedback about the effect of his behavior on others?

3. Particularly with involuntary clients, counselors must **understand and respond to impediments to change that arise as a result of the client's involuntary entrance into the counseling process.** Does the client trust the counselor or does he or she feel uncertain about disclosing information to the counselor? Does the client doubt the value of counseling? Is the client angry at the counselor because the counseling mandate was involuntary?

4. The counselor must **select a counseling approach appealing to the style of the particular client. How does the client learn? Through action-oriented techniques? Through insight? Through talk about feelings? By seeing someone else perform the new behavior?**

5. Counselors must **understand the points at which their clients may be receptive to new understanding.** What stage of treatment has the client reached? When should clients be confronted and when should they be allowed to "stew in their own juices?"

6. Counselors must **develop an awareness of self and of organization dynamics that hamper treatment.** How can the counselor **avoid inappropriate alliances with clients against other staff members?** How can the counselor **detect manipulation and respond therapeutically?** Is the counselor respond-

ing appropriately to the client's transference and is the counselor fully **aware of his/her own counter-transference reaction?**

7. Counselors must have **some method to understand clients' tactics of resistance.** How do clients evade personal responsibility by attacking or confusing the therapist? What is the best approach the counselor can use to respond effectively to these tactics from a particular client?[5]

Conclusion

Counseling with difficult clients can be challenging and gratifying as well as draining and frustrating. **Counselors need to determine whether their formal training is sufficient for understanding the problem of the help-rejecting client.** Fortunately, increasing attention in continuing education programs is directed to therapeutic techniques for working with special populations, such as drug offenders, batterers, public offenders, socio-economically deprived clients, and others. Therapists have a professional obligation to continue beyond their academic training and think deeply about the practical problems people face in our very troubled world. Most therapists would have very few clients if they worked only with those who were articulate and "motivated." It is essential to develop skills to be effective with clients we consider difficult.

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QUESTIONS BASED ON THIS LESSON

5. Which of the following statements is correct?

A. All resistance to change is bad

B. The counselor's job is to remove those resistances that are dysfunctional for the client

C. All resistance is rooted in resistance to particular counselors, not to the process of counseling itself

D. Transference problems giving rise to resistance to counseling are not important in clients who are coerced into care, such as those from correctional or substance abuse programs

6. Which of the following statements is correct?

A. Never give clients choices as to appointment times, topics to discuss, or even seating arrangements

B. Counselors should always expect clients to deceive them and take all steps necessary to avoid appearing gullible

C. It is easy to empathize with and share experiences, feelings, and values with clients who present seriously antisocial behavior

D. A most dangerous influence of a counselor's personality on the client is the unconscious encouragement of acting out, such as finding vicarious satisfaction in clients' sexual encounters or flouting of authority

7. If a counselor finds a client is getting consistently worse even though sessions seem to be friendly and productive, he or she should:

A. Review the progress of the case with another counselor/professional to try to find out why

B. Confront the client with this observation and demand that he or she improve while threatening to end counseling if improvement does not occur quickly

C. Refer the client to another counselor

D. Call for a psychiatric consultation for the purpose of initiating drug treatment

over, please...

8. Which of the following statements is correct?

A. Counseling with a difficult client never involves an active or passive struggle for control

B. If a client is expressing overt rebellion by refusing to participate in counseling sessions, become personally invested and never let the natural consequences of nonparticipation evolve

C. Select a counseling approach suitable to the style of each particular client

D. Use one counseling approach for all clients regardless of their individual personalities and problems

Directions in Rehabilitation Counseling

VOLUME 2 • LESSON 3

Child Abuse, Sexual Abuse, and Neglect

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EDITOR'S NOTE

Child abuse, including sexual molestation, is a disturbingly frequent phenomenon. Counselors engaged in treating children or working within educational or legal arenas are more likely to encounter the problem than many in practice. But all counselors should be alert to the possibility of such abuse since the effects on children are often devastating. Furthermore, the law requires that child abuse be reported, and professionals should acquaint themselves with the statutes of their own particular state.

In adult practice, most of us will be faced at one time or another with clients who were abused as children. Understanding the impact of such experiences on the client's development will facilitate resolution of the residual scars such clients bear.

Introduction

Changes in the mores of child-abuse reporting have expanded recognition of that serious problem and have catalyzed proliferation of scholarly and lay literature and such major databases as that maintained by the National Center on Child Abuse and Neglect (NCCAN), which consists of files on documents, research, programs, and audiovisual centers. Data from child protective agencies nationwide documented more than **one million reported abuse cases in 1983 and an increase in reporting of 19% over the next two years.** Moreover, most people in the field agree that the **problem is significantly underreported.**

Using a sample of about 400,000 children, the American Association for Protecting Children found the following proportions of maltreatment: **major physical injury, 3.2%; other physical injury, 32.7%; sexual maltreatment, 8.5%; emotional maltreatment, 10.1%; neglect, 58.4%; and other, including abandonment, 8.3%.** Some children experience more than one form of abuse. **Studies based on emergency room visits show two-thirds of children who come for treatment are less than six years of age, and about 60% are less than two years old. Adolescents constitute a second peak of frequency in parental violence.** Most studies find no difference in the incidence of abuse of males and females, but that varies with the ages of the children in the study. **Very young boys may be abused more frequently than young girls, but adolescent girls are probably abused more than adolescent boys.**

Child abuse may occur in all socioeconomic groups and all subcultures, but **child abuse and neglect occur more often in compromised, socially and psychologically damaging neighborhoods**

and are associated with high life-stress factors. Abused children tend to be part of families with higher child-to-parent ratios, either **larger families or single-parent families.** Ethnic differences indicate that abuse rates are **higher in nonwhite families,** but that is probably related to the confounding factors of poverty, divergent childrearing practices, and discriminatory attitudes among law-enforcement officials and professionals in reporting practices. Recidivism for child abuse is estimated at 50-60%; **Kempe** (1975) **estimated that a battered child is at 20-50% risk of permanent injury or death if returned home with no intervention.**

Clinical Features

Recognition and Diagnosis:

Abuse is blatant when the child presents with fractures, burns, bruises, or unusual injuries explained by implausible stories. **Documentation with radiologic, photographic, and standardized clinical examinations is still required.** Other cases, especially emotional abuse, are more subtle and difficult to detect.

Because self-reporting of child abuse is infrequent, persons other than the parent of the child are legally *mandated* to report cases. Most children are too young or too frightened to report being abused, and parents are reluctant to admit their actions because of guilt and fear of reprisals. "Doctor shopping" and seeking care in more than one medical setting are characteristic and make detection by the medical community difficult. Therefore, all adults who are in contact with children should be alert to the signs, symptoms, and indicators of abuse and should report cases, whether actual or suspect.

Indicators of Abuse:

Signs of abuse can be found in the parents and the child. **Abusive parents are often mistrustful, have a poor self-image, and are immature. They commonly have low frustration tolerance, poor impulse control, and either excessive hostility or apathy. They may be burdened by poverty, borderline intelligence, and/or substance abuse. They are often isolated from their own family and from others in their community. Psychotic or psychopathic behavior may be manifest. They themselves often have a history of being abused or neglected as children.**

Abusive parents may feel love for their children but exhibit a lack of concern, knowledge, or understanding about their child's medical, developmental, and psychological needs. They may seldom look at or touch their child, have unrealistically high expectations of the child at the same time they are excessively critical, and express belief in harsh punishments to keep the child from becoming spoiled. They may oppose the child's participating in activities outside the home. In their interactions with professionals, they may be inconsistent and difficult to locate.

The abused or neglected child may be tardy or often absent from school for extended periods of time. Alternately, the child may arrive early or linger after school. **He or she may seem to fear home and parents or be withdrawn, passive, have low self-esteem, and be uncommunicative, overcompliant, inattentive, self-absorbed, or unusually tired.** Fearfulness, defiance, changeable behavior or misbehavior, and difficulty relating to other children and adults may alternate with a hunger for affection that is tempered with little expectation of being comforted when hurt or upset.

Clinical Characteristics

The Children:

Abused children have an increased incidence of premature birth, congenital abnormalities, or low birth weight, and they frequently experience lapses of child care such as missed immunizations, erratic treatment of illness, and poor hygiene. **A physical examination may show scars, bruises, or burns** with new lesions atop older ones. X-rays may show repeated fractures that are in varying stages of healing. Neurologic sequelae are important: Caffey described chronic subdural hematomas that result from violent shaking of the infant's head. IQ and cognitive studies show **lower school success and language delays,** both causes and effects of abuse and neglect. One review of records of children in an institution for the mentally retarded indicated that for 3-11%, retardation resulted from injuries caused by abuse.

Typically, abused children have experienced dyssynchronous, nonempathic early care, either because of constitutional factors in the child, inadequacies in the parent, or both. That early experience begets symptoms that perpetuate the child's problems. **In studies of structured play settings, mistreated preschoolers demonstrate social and affective withdrawal,** which could be a reflection of having been rebuffed; **lack the pleasure so important in caregiver-infant bonding; are inconsistent and unpredictable; show shallowness or fickleness;** and are ambivalent and ambiguous in affective expression or negative affective communications. Friendly invitations from a caregiver or another child put abused children in an intense approach-avoidance conflict. Such children approach teachers only half as often as nonabused peers and tend to approach indirectly, by angling toward, backstepping, or coming near from the adult's side. Their attachments have an anxious quality. **Aggression develops more frequently in abused children, especially if they are boys or are young when abused.**

The abused child may have certain characteristics which draw abuse upon him. The child may have **special significance for the parent, physically resemble a dislike family member, be developmentally delayed or handicapped,** or have **a chronic medical problem.** Children with early medical complications, or who for some other reason have been separated from the parents so that bonding failed to occur properly, may be vulnerable to child abuse. The chronically ill child poses great demands on the parent and may be a constant reminder of the parent's sense of inadequacy and failure. "Von Munchausen by Proxy," a peculiar variant of child abuse that has received attention in the literature, is diagnosed when a parent creates physical symptoms in the child, such as putting blood in the child's urine, that result in the child's undergoing sometimes-painful diagnostic procedures.

The abused child learns to think of himself as bad, worthless, and deserving abuse. Frequently such children are difficult to like, defiant, or oppositional, and they have behavior problems that contribute to the abuse cycle. Those characteristics may carry over into the child's contacts with peers, teachers, relatives, and others so the child engenders negative feelings in other settings. Some children learn that their expected role in the family is to be bad, and they oblige by being bad and getting punished as a way of relieving tensions between other family members.

The Families:

Stress factors, such as too many children, poverty and unemployment, substance abuse, family discord, or difficult temperament in the particular child, may contribute to one child being selected as a target of abuse. **Several studies of abusing parents find that they are nonempathic, impassive, or abrupt in their interactions with their children,** even though they engage in many activities directed toward the child. **Parental response to the child is inconsistent,** and inability to adjust to the child's developmental level is very common. Frequently abused themselves as children, the parents may have been expected to perform physical and emotional tasks beyond their years and to take care of and nurture their own parents. In return, they may have received rejection and criticism but little nurturing. Childhoods centered on attempts to please parents produced intense fear of rejection and criticism and a metastable sense of identity. Such children become adults and parents with fragile trust, low self-esteem, poor frustration tolerance, and an expectation that others would fail them. They may have disengaged themselves from their parents, their spouses, and helpful persons in their community. Unable to provide their children with care and nurturing, **they repeat the same pattern they experienced themselves. Their child's crying, mischievousness, or other behaviors are perceived to be personal attacks or intolerable reproaches** by the parent whose emotional immaturity and frustration intolerance makes them vulnerable to sliding from normal anger to a rage in which they lose control over their behavior toward their own child.

Other characteristics of abusive parents are role reversal, self-righteousness, and ambivalence. As their parents did with them, **abusive parents may expect their child to take care of them and may see their child as there to meet their own needs or as an object of their harsh criticism. Often, abusive parents feel that the child is their property,** thus justifying their beating the child to teach him a lesson when he cries or becomes demanding or disobedient. **Ambivalence** results from the abusive parents' love of their children conflicting with their own unmet needs, rage, and frustration. When they are overwhelmed, they strike out at the child. That **explains the intermittent nature of most abuse, the strong parent-child bond, and the severe disturbance caused when someone attempts to disrupt that bond.** With a strong need to succeed as a parent, the vulnerable parent recognizes having a child removed from their care signifies failure. Although ambivalent about intervention and often violently protesting it, parents are frequently relieved when an intervention is made, all the while blaming the child welfare agencies and expressing suspicion and plausible feelings, sometimes accurate, of having been victimized.

Intervention and Treatment

No amount of understanding of familial and social causes of child abuse reduces the need for intervention and treatment for the abused child. Intervention for child abuse frequently requires several disciplines: medicine, social services, legal services, child advocacy, and mental health, ideally organized as a well-coordinated treatment team with six goals. **Protection of the child is the first priority.** It requires acute intervention, including acute medical and surgical care, and immediate institution of measures to deal with acute sequelae of physical abuse. **Reporting with adequate documentation is mandatory.** Rapid assessment of the child's and family's environment, and diagnostic evaluation of the child and family are necessary before any dispositional arrangement or sensible treatment program can be developed.

The first treatment principle is an emphasis on keeping the child in the home or returning the child to the home as soon as possible. If neither of those is realistic, the child should be placed in a permanent, stable family situation as soon as possible. Long-term, comprehensive intervention is usually necessary and may require strong professional advocacy, as the acute needs of many new cases could deflect resources from children currently in treatment. Lastly, **ongoing evaluation of the efficacy of the intervention** should be part of the program.

Secondary prevention is possible even though intervention occurs late in the cycle of abuse. Among the obstacles to prevention are the child's behavior problems that may have developed as a result of the abuse and the parents' inability to change their parenting patterns and their alienation from the social service system. **The child and the parents should have different counselors** so the child has an ally and the counselor does not have difficulty with countertransference. The parents' excessive needs may jeopardize the child's treatment if they effectively compete for the counselor with their child or feel criticized when the counselor is sympathetic to the child.

Meeting the needs of abusive parents is taxing and difficult. It requires outreach and other treatment extensions and a persistent

treatment alliance even when the parents reject, run away, or reproach the counselor. It requires a consistent, warm, nonjudgmental attitude. **It may require home visits, extensive interagency coordination, responsiveness to crises, and toleration of parental dependence on the counselor.** Once that dependent and nurturing relationship is established, the counselor can allow the parents to experience being cared for and gradually to become independent and assume increasing responsibility for their own lives. The first stage is arduous and may require months or years. The feelings of the counselor and team members in response to the parents' behavior may be difficult to tolerate, and it requires much restraint and self-understanding not to act out those feelings with the parents or with the child. To do that, the counselor must be able to confront the parents' actions without experiencing them personally. A person or group that can provide support, ventilation, and resolution of these feelings is extremely useful.

Following the team-treatment phase, **the second phase allows the parent to assume more independence, which is also a slow process.** The counselor must encourage, but not demand, growth and must guard against the parents' becoming overly dependent. The parents' gains are precarious and easily eroded by situational setbacks that may cause them to revert to low self-esteem, dependence, and impulsiveness. Those lapses must be accepted nonjudgmentally. If they can be overcome, the parents will continue to make steady progress. A consistent counselor is important throughout this process. **The ideal is to share case management with at least one other professional, thus allowing the parents to have someone available at all times and to allow the counselor relief and support. That approach also helps the**

parents learn that more than one person can be trusted.

Team difficulties frequently develop when a number of professionals and paraprofessionals from different fields attempt to work together. They include poor communications; territoriality, as each professional emphasizes his or her own diagnosis, treatment, or theory; and professional jealousies. Frequently the counselors are overworked and may also be undertrained, which adds to the inherent frustration. The chronicity and severity of the problems may demoralize team members, particularly in a mental-health-care epoch marked by lack of resources. A team leader with good organizational skills who can encourage mutual respect and cooperation in providing comprehensive services for children and families can avert much strain. When functioning well, the team can offer mutual support to its members by sharing feelings and frustrations.

Most parents can be helped by the treatment process described above, although they may not be cured or become model parents. They may be able to assume effective and appropriate care for their children and experience more fulfillment in their lives. The intervention should be conducted by carefully screened, sensitive individuals who have had good parenting themselves, who are specially trained and who are supervised, but the primary counselor need not always be an expensive, highly educated professional.

Legal Aspects

All states now have mandatory reporting laws for child abuse under the civil code. These laws vary from one region to another and are frequently revised. Professionals should be acquainted with the

statutes of their own state or obtain information from advocacy groups such as the state attorney general's office and local courts. Each state has an age limit below which reporting is required, usually between 16 and 18 years. Reporting criteria range from mere suspicion of abuse or neglect to having "just cause" to believe physical abuse has occurred. Some states consider neglect and abuse together and others differentiate them. Some states require anyone to report, whereas others require only physicians or other professionals who are notified by a physician to report. All states grant the reporting person immunity against criminal or civil action, and many state statutes contain a penalty clause for failure to report abuse.

Most state statutes designate a particular agency to be the recipient of reports and provide specifics regarding the substantiation of abuse and follow-up. That is usually mandated within a specific time period. All states have criminal prosecution statutes for physical abuse, which is considered assault. Those statutes are used less often as states focus on providing services to abused children and their families. If necessary, legal actions are taken through the civil route.

Most states waive confidentiality provisions so that physicians and others can be required to divulge information in the course of reporting and investigation. Most states have procedures for interviewing the child, for ascertaining the safety of siblings, and for emergency detention with or without parental consent. All states require the parents be given a Miranda warning before they are interviewed if criminal prosecution is imminent, and some states grant children and parents the right to counsel.

Custody Decisions:

The prevailing philosophy of treatment advocates custody and placement of the child in his or her own home when possible and engaging parents in a voluntary treatment program even after abuse is confirmed. However, no child welfare agency in any state is equipped to provide all its cases with ideal treatment. A lack of resources and a lack of appropriate knowledge may result in custody or placement of the child outside a potentially salvageable home, thus creating additional stress that may be heightened by punitive attitudes on the part of social services or legal professionals.

If possible, avoiding court is best, as it is frequently a destructive experience. During court proceedings, people who have been or will be working with the parents are required to give evidence against them. Judges and juries must consider the child versus the parent and may decide in the child's interest, which is against the parents' will and which alienates them and makes them feel betrayed by many parts of the support system. A proper investigation and gathering of evidence may subject the parents and their helpers to a grueling exposure of their conduct, psychopathology, and history. That process, painful to the parent, negatively influences those who may need to work with them.

If the parents' refusal to cooperate with treatment places the child's health or life in danger, the case must be taken to court. The court may then decide on custody after considering social service information. **Options include placement and custody in the original home with state supervision, custody with the state and placement with a foster family, or termination of parental rights with permanent**

adoption. **The expert witness is crucial to a court case.** Experts' reports must contain organized and factual information and opinions; recommendations should be stated concisely and be based on facts about the case as well as known concepts in child development.

Sexual Abuse

Incidence, Prevalence, and Problems of Reporting:

An estimated 12 million children are sexually abused each year in the United States. The prevalence of persons who report both contact and noncontact abuse ranges from 19% to more than 50%, depending on the methodology of the study and the definitions of abuse and sexual abuse. **One third of victims are children six years of age or under. Preschoolers are more likely to be molested by a family member, and females are victimized two to four times more often than males.** A random survey of 2,627 adults selected from the Los Angeles telephone book found that 27% of females and 16% of males reported they had been sexually abused as children, but only 3% reported this abuse to an authority. Seventy percent of those who reported the incident said that reporting had no effect. **The rate of repeated offenses among treated adult sexual abusers is 75% to 80%.** Reporting increased by 59% between 1983 and 1984, according to the Child Welfare League of America. However, not all cases are reported, and of those reported, only 42% are substantiated according to American Humane Society statistics for 1984. The many reasons for failure to report include fear, denial, and belief that changes will not occur after reporting. Delayed reporting occurs as a result of those factors and because of the victim responses described below. **Underreporting**

undoubtedly occurs. Intimidation of the victim is a routine concomitant of child sexual abuse and the child may disclose the molestation only after a long period of time. It is also known that overreporting may occur in the context of disputed custody, because the *allegation* of sexual victimization is one way to obstruct a child's placement in the care of the accused adult.

Clinical Aspects

Physical Features:

The physical manifestations of sexual molestation are usually soft-tissue injuries, such as bruises and lacerations, which may heal rapidly. Unless the victim can be examined promptly or unless sophisticated methods can be used to verify previous injury, the testimony of the victim is the only documentation. New pediatric approaches include standardized protocols and examination using magnification with colposcope for physical signs of microtrauma. Photographs may be taken to collect medical and legal evidence for permanent documentation. In one study the occurrence of lesions in sexually molested girls was compared with that in asymptomatic girls and girls being seen for other genitourinary complaints such as vaginitis or dysuria. Genital trauma, such as scars, attenuation of the hymen, synechiae, or friability, was significantly increased in sexually abused girls as compared to asymptomatic girls. Many such findings occurred in girls with other genital complaints, however, suggesting either that vulval inflammation might lead to some of those symptoms or that those girls had been molested as well.

Psychosocial Aspects:

Presenting psychiatric symptoms include some features that may occur in victims of any age and others that are relatively specific to the developmental age of the child. The act of being sexually abused can precipitate both pseudomaturity and regression. Clinical versatility can differentiate psychological evidence of sexual abuse in a youngster's behavior from the background noise of the typical traumas of life and developmental thrusts.

General and nonspecific symptoms that may occur in preschoolers, school-age children, and adolescents **include anxiety, guilt, phobias, withdrawal, disturbances of appetite and sleep, somatic complaints and conversion hysteria, and eroticization, the appearance of sexualized behaviors. Preschool children may be more likely to react with renewed aggression, hyperactivity, lying, separation fears, and signs of impaired trust. Older children and adolescents may develop school problems, run away, engage in delinquent or acting-out behaviors, abuse drugs, become depressed and attempt suicide, or display tics, borderline states, aggression, or even obsessions and psychosis.**

The seriousness of psychological effects is not well-correlated with the severity of the abuse. Not only is there a continuum of abuse but also the resilience of the victims and the personal or family support available to them may vary. Many studies have reported on groups of molested children and adolescents and have sought to find a pattern based on the relationship of the perpetrator and victim. **It appears that a single incident of molestation by an unrelated person is less psychologically damaging than ongoing**

incest with a trusted adult. The most common patterns are incest between fathers or stepfathers and daughters, followed by other adult male family members with girls, followed by brothers. Incest between adult women and their young male relatives is quite uncommon and appears to be associated with much more severe psychopathology in the perpetrator.

For the victim, the abuse that is experienced may be more than sexual depending upon the emotional context in which it occurs. That is especially true in the case of incest. **Part of what the victim experiences depends upon the aggressor's motive.** For the older person who abuses a child, it may be a drama of overpowering or manipulating a vulnerable person, a reenactment of a childhood trauma of the perpetrator in an intimate context with a specially chosen victim, or a combination of either of those two motives with real affection. **In cases where the abuse is incestuous, the impact is tremendous.** At the level of the child's individual relationship with the molester, the victim endures the **betrayal** of a child's right to be cared for by adults. Studies have shown that, at the family level, roles are often distorted, and that **sexual molestation of children seems likelier to occur in families that are isolated, in which the marital relationship is troubled, and where communication is closed, subterranean, or bizarre.** A child in such dysfunctional families not only lives under the emotional fallout of sexual abuse but also faces the problem of experiencing **trauma in a interpersonal milieu with impaired communication that hampers opportunities for corrective experiences.** Such factors compound the trauma, contribute to a cumulative insult, and confound the counselor's understanding of the extent to which molestation alone contributes to the child's symptoms. **Further complicating the situation are the emotional, social, and economic consequences of civil and criminal proceedings that may occur if the child discloses the abuse.**

Diagnostic Approaches:

Clearly, no simple psychosocial patterns are apparent, and therefore no one formula for such evaluation suffices. Proof of sexual molestation can best be obtained by a careful physical and pelvic examination using colposcopy and documentation with photographs. **Psychiatric evaluation has been sought to provide post hoc documentation in cases where the physical examination has been omitted or where findings are equivocal. However, important functions of psychiatric evaluation are assessment of the emotional damage wrought by the molestation and treatment planning.**

Much has been written about how to interview the child, the use of anatomically correct dolls, clinical videotaping to document the often-eloquent nonverbal communication of a very young child, and family involvement in the diagnostic exploration. For the reasons described in the previous paragraph, it is necessary to **tailor the evaluation of the child and family to the individual case.** Psychopathologic sequelae of sexual molestation may be protean and severe. For example, in a population of hospitalized latency-aged children on an inpatient psychiatric unit, Livingstone found **sexually molested children had greater frequencies of psychotic symptoms, major depressive disorders, and somatic complaints in comparison to physically abused children, who tended to manifest conduct disorders.**

The victimized child's coping responses and defenses are vigorously mobilized and have their own effect on later learning and experience. Improved clinical recognition will strengthen expert testimony and assist in treatment planning. For example, Summit has described a characteristic **Child Sexual Abuse Accommodation Syndrome: (1) secrecy, (2) helplessness, (3) entrapment and accommodation, (4) delayed, unconvincing disclosure, and (5) retraction.**

Certain diagnostic features may be specific to sexual victimization. The National Summit Conference on Diagnosing Child Abuse, held in October, 1985, proposed a category of "Sexually Abused Child Disorders" be included in DSM-III-R. The category, Sexual Disorders of Childhood, would encompass the eroticized child and a "post-traumatic stress disorder" with specific categories for children. The conferees believed many sexually abused children fit the latter category, so counselors could use Axis III to indicate sexual abuse.

Legal Considerations

The Child as a Witness:

During the 1970s, professional opinion moved away from recommended therapeutic approaches to deviant behavior to a "get tough" punitive response, with increased emphasis on prosecution. As a deterrent, many state legislatures enacted mandatory reporting laws and recommended harsher penalties for abuse. An unfortunate consequence of the increased reliance on litigation was a greater demand for testimony by the victimized child. That often imposed further stress upon the child. Indeed, the psychological harm resulting from participation in adversarial proceedings has been termed a "second victimization."

Our criminal code permits the accused to confront his accuser, but when the accuser is a small child who is frightened of the court and of the molester, the confrontation can be very painful for the child. Putting the child on the stand forces weighing retraumatization by inquiry against the perpetrator's evading punishment, thus leaving the child to feel no retribution is possible. Moreover, the child's poise may dissolve on cross-examination, and he or she may be unable to convince the court of the truth of his or her testimony. Goodman's **research on children's testimony indicates testimony given by a child is less likely to be believed by juries than the same testimony given by an adult.** Nonetheless, Claman has asserted **testifying need not be traumatic for the child if it is properly handled.** For some youngsters, testifying enables them to actively transcend the role of the victim and gain more control.

Extensive discussion has been devoted to the question of whether the child does or does not lie in court. No absolute answers exist. **Each child must be carefully evaluated for his or her perception of the question, of the event, and of the consequences of what is said.** Children are slower to understand questions and generate answers. A young child may appear to lack consistency in reporting or to be fusing or confusing the facts. If the child's family has failed to teach wrong from right, such knowledge cannot be assumed in the child witness. A child may not know the meanings of terms such as molest, abuse, penis, vagina, or anus. Children imitate, and they are suggestible and compliant with parents and adults whom they seek to please or protect. Children may not understand or be informed of the consequences of their statements or acts. For any witness, the memory of complex events is subject to error on recall, and emotional flooding may increase misperception. The child's sense of time may be immature, so a developmental assessment should affect the listener's interpretation. For example, usually a five-year-old is unaware of the calendar date. A child who gives exact dates on the stand may have been coached. The investigational procedure itself is a powerful experience for the child, and the memory of an actual event may be contaminated by memories of intervening descriptions of the event. When an adult with whom the child has shared the story testifies for the child, it is considered hearsay evidence: such testimony can be given in some jurisdictions without the accused having the right to challenge its accuracy.

The Role of the Expert Witness:

The role of the child psychiatrist, psychologist, counselor, or pediatrician may be **to evaluate whether the child should testify, to more thoroughly evaluate the family with regard to possible false allegations, to prepare the child to testify, and to debrief the child afterward. Depending on whether the case is being heard in civil or criminal court, the expert witness may be asked to address the question of damage to the child, to field hypothetical questions concerning the dynamics of child sexual abuse and ensuing psychopathology, or to testify on what constitutes an adequate evaluation of child sexual abuse.** Other roles include assisting attorneys in examining a child and even consulting with defense attorneys. **The approach to gathering information and managing confidentiality in the consulting room is very different from that in the adversarial legal system, and it behooves the expert to clarify those roles explicitly.** The case report and testimony should contain organized factual information. Opinions and recommendations should be stated concisely and should be based on facts about the case as well as established concepts of child development.

In cases that concern the granting of sole custody of a child to one of the parents, experts must attempt careful screening to protect the child from abuse and the parent from wrongful accusations. In reviewing incest accusations from custody cases that were referred to a forensic or specialist child psychiatrist, Benedek and Schetky were unable to substantiate 55% of allegations. In contrast, Green found only 36% of accusations false. That points up the importance of distinguishing between allegations that are false and those that are unsubstantiated. One must also remember only the most vexing and ambiguous cases get referred to forensic or specialist child psychiatrists, creating a potentially biased sample.

Sexual Abuse Treatment

Primary Prevention:

Increased awareness of child sexual abuse has sparked debate about the openness of sexual information in schools and has led to well-designed films and community educational campaigns to teach children about "OK touching and Not-OK touching," the (bad) "Oh-Oh feeling," and that the child can "Say No!" Although early post-test findings suggest that, unfortunately, **these programs may have a very limited impact** and may not equip the child to make crucial social discriminations about potential abusers, **they may have the indirect effect of sensitizing adults who care for children to the signs of strain that children may evince when they are threatened or abused.**

Secondary Prevention:

Although a thorough diagnostic evaluation of the child is required by law, **acute intervention by the counselor can have a powerful effect. That means situational intervention, including accompanying the child to court as well as talking about the molestation in the counselor's office.** Unquestionably, the counselor who sustains a supportive relationship with the child through the disclosure crisis and the often-prolonged familial and legal repercussions can provide a beneficial effect. In psychotherapy, the child can be helped greatly by having a private space to talk and play out his or her experiences and attain some mastery of them. **Involvement of the child's counselor in the civil or criminal proceedings complicates the therapeutic relationship,** as the counselor may be impelled into a more-investigational approach to the child and unwillingly become yet another adult who invades the child's personal space. **Multimodality approaches including family therapy are often necessary.** The counselor should expect any molestation case to evolve from crisis through accommodation and slow resolution. Later working-through must occur when the child has to navigate the next developmental phases, particularly the tasks of approaching intimate relationships in adolescence. The chronicity and severity of the sequelae of sexual victimization mean **adequate treatment is long and costly,** a fact that is discouraging for patients and for health care workers in an epoch of decreasing availability of mental health care reimbursement.

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QUESTIONS BASED ON THIS LESSON

9. Which of the following statements is correct?

A. Only 4% of child abuse incidents involve sexual molestation

B. It is estimated that a battered child is at 20-50% risk of permanent injury or death if returned home without intervention

C. Health professionals cannot report child abuse cases if such revelation violates the rules of confidentiality

D. Most child abuse incidents are accidental, the result of brief emotional outbursts on the part of otherwise quite stable parents

10. Which of the following clues may suggest the existence of child abuse?

A. Absences from school for prolonged time periods

B. Withdrawal, passivity, and low self-esteem

C. Fear of home and parents

D. All of the above

11. Among the features of abused children that may particularly draw abuse on them from parents are:

A. Adopted status

B. Only-child status

C. Physical resemblance to a disliked family member

D. Unusually good physical health

over, please...

12. Which of the following statements is correct?

A. The experience of sexual abuse can set the stage for later sexual difficulties, but rarely has an impact on personality development

B. The least traumatic form of sexual abuse is ongoing incest with a trusted adult

C. Child sexual abuse is more common in families where closeness, a good parental relationship, integration within the community, and good communications exist

D. Sexually molested children appear to have greater frequencies of psychotic symptoms, major depressive disorders, and somatic complaints as compared with physically but not sexually abused children

Directions in Rehabilitation Counseling

VOLUME 2 • LESSON 4

The Understanding and Management of Chronic Pain

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Directions in Rehabilitation Counseling
VOLUME 2
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EDITOR'S NOTE

Chronic pain is not an easy target for treatment. It involves numerous overlays, including depression and anxiety, symptom gain, and chemical dependency. In our culture, physical pain (although not emotional pain) holds a position of respect; those who suffer pain are often given gratification that even an adequately adjusted person finds hard to resist. However, the fact that observers find it difficult to grasp the meaning and reality of pain can make their responses vary from overprotectiveness to outright rejection.

Nearly 60% of clients with chronic pain show some depression; 25% show a defined mood disorder. Pain management programs involving a wide spectrum of treatments, including behavioral modification techniques, have become popular and useful.

Introduction

As the duration of a medical disorder increases, so usually does its complexity. In some instances, the initial pathologic process is progressive; in others it merely smolders on or may even have run its course. Increasingly, the symptom picture is dominated by the ongoing effects of chronic distress, the person's adaptation to the illness, and iatrogenic factors.

Chronic pain is an example of such a situation. Often, it is initiated by injury or acute illness, and then the initiating condition becomes nonprogressive but the pain persists. Years later, the pain continues to dominate the client's life and associated objective findings are vague or static.

The client with persisting pain has usually been in treatment with various medical specialists, but relatively few such clients have seen counselors. **Often, the chronic pain client resists counseling, while many physicians hesitate to refer.**

Most astute counselors will recognize that **a client's chronic pain complaint involves components of symptom amplification, symptom gain, hypochondriasis, depression, anxiety, somatic delusions, chemical dependency, and marital discord.** Irrespective of one's theoretical framework, these factors require recognition and consideration in establishment of an appropriate treatment program. However, in a pain clinic setting the counselor usually works as a member of a multidisciplinary group and various theoretical viewpoints are held by other specialists within the group. It soon becomes apparent that there is a lack of a widely accepted conceptual model in which biopsychosocial factors are well integrated. The counselor needs to sort out his own viewpoints on pain.

General Concepts

Acute pain usually occurs contemporaneously with a definable, peripheral, noxious stimulus; chronic pain often does not. It is unlikely that chronic benign pain will be explained by the prevailing peripheral-anatomic-specificity theory which is applicable to acute pain. Various theoretical models are available to explain the lack of objective findings in this type of chronic pain.

The "Gate Control Theory" emphasizes the role of central processes in modulating transmission of pain. In this construct, ascending and descending messages influence each other and this includes an input from cortical centers. Although it has acknowledged deficiencies, this theory has led to a more realistic understanding of peripherally induced pain.

Biochemical findings of an internal analgesic system are further evidence of the integrative processes of central pain. Even though our understanding of the endorphin system and associated neurotransmitters is incomplete, related research has clearly shifted our thinking centrally. The fact that anatomic, neurochemical, and psychologic factors influence central endorphin production has major implications in terms of their influence on chronic pain. Possibly, central endorphin-neurotransmitter dysfunction may alone cause pain or alter the impact of a trivial peripheral disorder.

Various psychologic interpretations of chronic pain have been proposed. These emphasize that pain is an abnormal affective state and not a primary perceptual experience; that impulses are electrical activity occurring in nerve fibers but they are not pain. The capacity to experience pain develops from peripherally induced experiences, but thereafter the pain experience may occur without corresponding stimulation of the end organ and may be linked to aggression, loss, guilt, anxiety, and depression, in addition to serving as a mode of communication.

Benign, nonprogressive chronic pain can be conceptualized as a central neuropsychologic disorder, not unlike the syndromes of anxiety and depression. The syndrome consists of **nearly constant discomfort, increased self-concern, impaired adjustment, increased dependency, secondary depression, and medication misuse.**

The etiology is obviously unclear. It has perhaps resulted from a neurochemical abnormality in the endorphin or serotonin system or, in other instances, improper psychological programming. By focusing on a peripheral anatomic viewpoint of pain, the end result is chronic impairment of the person who has not been successfully treated.

Evaluation of the Chronic Pain Client

Prior to working with the pain client, **a comprehensive general medical evaluation** is necessary. Clarification of any existing peripheral organic disease may also require subspecialty consultation within the areas of neurology and orthopedics. This evaluation is necessary to exclude reversible pathology, to facilitate an effective plan of noninvasive therapy, and to reassure the client.

Pain History:

A pain history is the first step in evaluation of the client. (See

Table 1.) A firsthand description of **circumstances surrounding the onset of the pain problem** is important. **Accumulated evidence of repeated negative examinations, unsuccessful surgical procedures, or treatment failures increase the chances that now a central neuropsychologic component is playing a significant role. In checking for associated complaints, vegetative symptoms of depression are most important.** Their presence is notable even though **the client**, who has chronic pain, **typically attributes them to the discouragement of living with pain, and thus denies depression.**

History of drug use is another important area. **Drug dependency is usually well disguised,** both from the physician and the client. To clarify this issue, one must not be distracted by the relative need for medication, the seemingly unquestioned right of the client with pain to whatever medication will help, or the opinion of physicians.

If the client has a history of a chronic or recurrent medical problem in childhood, the response pattern may be repeated when a problem with pain develops in adulthood. A variation of this theme is the existence of **a parent or sibling who has a chronic pain problem** and perhaps serves as a model for the client's pattern of morbidity.

Behavioral Examination:

The behavioral examination begins while the counselor is taking the pain history. (See Table 2.) **The client's description of the painful area and of changes he has seen** (swelling, discoloration, twitching), **felt** (knots, spasms), **or heard** (grinding, crushing) for which there are no significant objective findings are good indications of central amplification factors.

TABLE I
Components of a Specific Pain History

- Pain complaint
  - circumstances related to onset of pain
  - length, location, duration, and quality of pain problem
  - number and type of hospitalization, surgical procedures, and other treatment procedures
- Associated complaints
  - sleep, appetite, energy level, interest level, and mood
- Drug use (pain-related)
  - specific medications and 24-hour intake
  - length of analgesic-sedative-tranquilizer use
  - attitude toward medication
- Occupational and economic aspects
  - years on present job; stability of employment
  - time off work because of pain
  - compensation received per month and duration
  - litigation received or pending
  - client's attitude toward job
  - employer's attitude toward pain problem
- Family and social aspects
  - ability to function in home
  - spouse-family attitude toward pain problem
  - influence of pain on sexual activity
  - effect on social activity (withdrawal)
- Past history
  - educational level and adjustment
  - age when starting work
  - presence of chronic medical problems (as child and adult)
  - number of surgical procedures (other than current pain problem)
  - accident proneness
  - alcohol or drug use
  - psychiatric disorder
- Family history
  - chronic medical problems in parents or siblings (specifically pain-related)
  - disability in family

It is useful to **have the client estimate the severity of pain.** This can be done **on a 0-10 scale,** 0 being no pain and 10 the maximum pain one can imagine experiencing. This subjective estimation of the pain level by the client allows comparison of the observed features of pain and a specific determination by the client. Visual analogue scales may also be used.

A variety of **test instruments** assist in evaluating the chronic pain client. You might consider the **Minnesota Multiphasic Personality Inventory** (MMPI), **McGill Pain Adjective Checklist, Pilowsky Illness Behavior Questionnaire,** and the **Hamilton Depression Scale.**

TABLE II
Mental and Behavioral Status Examination

Pain behavior
    - description of pain (quality, change)
    - verbal and nonverbal pain behavior
    - subjective pain level (scale of 0-10)

Attitude
    - distortion of medical opinion
    - distortion of past counseling
    - acceptance of counseling

Nursing and family observations
    - demand for continuous case
    - drug-seeking behavior
    - conflicts with paramedical staff
    - rejection of encouragement and help
    - withdrawal

Minnesota Multiphasic Personality Inventory (MMPI)
    - high neurotic triad (physical complaints and depression)
    - conversion V (physical complaints with unrealistic lack of concern)
    - elevation of Sc (unusual mentation, feeling of alienation)

Finally, **a working diagnosis** is in order. In practice, a complex mixture of structural-psychologic-social factors is the rule and it is difficult, if not impossible, to confirm the priority and etiology of pain, i.e. organic peripheral pathology vs. psychiatric disorder. **DSM-III-R has two Axis I diagnostic categories that are often applied to the chronic pain client: somatoform pain disorder and psychological factors affecting physical condition. Both have limitations. A more practical designation is "chronic pain disorder" to which can be added further description,** e.g., "including components of chronic radiculopathy, depression, central pain amplification, and medication dependency." Of course, these components could also be listed as separate diagnoses.

Complicating Factors

When first seen by a counselor, the typical chronic pain client has had pain for 5-10 years and intervening factors have usually increased the complexity of the problem. Although the pain exceeds objective findings, some clients have residual peripheral disease which contributes to their symptoms. Usually, there have been extensive efforts at previous treatment--surgically, medically, and perhaps even psychologically. **Iatrogenic factors often exist.** Finally, the client has had extensive interaction with the social system. These factors require specific recognition if management is to be successful.

Sociocultural Factors:

In our culture pain holds a unique position of respect not accorded to man's other travails. The individual who complains of pain is usually accorded respectful attention by family, friends, and employer--

particularly if medical evaluation produces some diagnostic label for it. Special consideration, which would not be given otherwise, is often given the client.

The concern of others and decrease of demands becomes intimately associated with the pain problem. **Being in pain may offer gratification that an adequately adjusted person finds appealing;** more so the deprived or stressed person or the one with psychologic impairment.

Economic Factors:

Many clients disavow a relationship between their pain and money; they profess a wish to return to work if pain is removed, and this is seemingly their genuine, conscious intention. **Most chronic pain clients have an adequate work record without evidence of malingering or deception. Nevertheless, potential financial reward and security profoundly increase attention to the painful area.** Whether to work in the presence of distress or to accept a declared disabled state with steady financial reward is a difficult dilemma for anyone. **To preserve respectability, a client usually must deny the importance of economic factors.** Face-saving efforts are necessary, and varying degrees of anxiety, defensiveness, indignation, hostility, and increased morbidity are frequently encountered.

The contribution of **legal factors** overlaps with these economic issues. This is an area in which the counselor finds it most difficult to function objectively and to assure that the client's best interests are served.

When injury is done, the victim has a right to compensation.

Deprivation of some bodily capability or impairment of well being generally entitles the client to some sort of allowance from an adversary or from society in general. The means to obtain this is through the legal system; however, **the adversary system promotes an emotion-laden interaction involving the client.** Under these circumstances even the most independent and well-motivated person becomes focused on his or her pain. **Morbidity is often increased** and effective treatment may have to be set aside until litigation is resolved.

Family Issues:

While pain is a private sense of hurt, a subjective phenomenon known only to the afflicted person, it does serve a communicative role between the client and persons around him. Extensive communication develops between family members in this situation. **This pain communication does not always work to the client's advantage.** A high degree of mutuality is usually associated with the pain problem that has itself become important in the family equilibrium. **The pain complaint becomes a method of communicating concern, affection, demands, and hostility.** It is used to control each other or serves as a method in which both the client and the relative control others. These issues necessitate that family members participate in the treatment of chronic pain.

Chemical Dependency:

The typical chronic pain client is using two analgesic or sedative medications and sometimes alcohol. For this type of client, **chemical dependency is a major risk.** About one-half of these pain

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clients abuse medications or are frankly dependent on them. Polypharmacy is a typical pattern.

Naturally the pain client seeks pharmacologic relief; it is prompt, simple, and advocated by physicians. **Unfortunately, chronic pain and its associated insomnia, tension, and fatigue do not respond satisfactorily to current analgesics and sedatives which are useful in managing acute pain. Soon the chronic pain is complicated by medication side effects, psychologic dependency, or physical craving.** The psychological presentation of the chronic pain client typically involves the following drug effects: **subtly impaired cognitive functions, drug-seeking behavior, diminished motivation, social withdrawal, and amplification of pain.**

Depression:

The relationship between chronic pain and depression is of particular clinical importance. The reported incidence of depression in clients with chronic pain varies widely. **Approximately 60% of chronic pain clients show some depression, 25%, a defined depressive disorder, and 5% fulfill the criteria of endogenous depression.** The causal relationship between chronic pain and depression is unclear. **Is pain a depressive symptom or is depression a result of chronic pain? Is there a shared mechanism involved?** While the answer is unclear, the depressive component of chronic pain requires clinical attention which should involve the use of an **antidepressant medication** and other indicated therapies.

Psychiatric and Psychologic Treatment Modalities

In the treatment of chronic pain, any treatment that works, without increasing morbidity, must be considered. This especially applies to modalities that might for some reason remove the pain. The chronic pain client deserves to be referred for consideration of surgery, anesthetic block, analgesic agents, electrostimulation, acupuncture, or any psychiatric modality that might produce relief.

Electroconvulsive Therapy:

As noted previously, depression and pain often occur simultaneously. Case reports of successful electroconvulsive therapy (ECT) use in those with pain and suicidal depression, or pain as a component of a delusional system, have been documented. However, early relapse into pain and depression is common. In instances of chronic pain, **the use of ECT can only be justified if there are clearly other psychiatric indications.**

Pharmacotherapy:

Extensive evidence indicates that anxiety associated with the painful stimulus causes an increase in a client's report of pain. In clinical settings, **anxiety is often associated with the acute pain accompanying myocardial infarction, trauma, infection, and surgery.** In such situations, **minor tranquilizers are a useful adjunct to analgesics**. Anxiety also accompanies the pain of progressive disease such as cancer. Again, the primary mode of pain control is the analgesic but modest amounts of a tranquilizer are helpful.

Since chronic nonprogressive pain is often accompanied by

depressive symptoms, a trial of an antidepressant is indicated. The mode of action is unclear: therapy of the depression or some nonspecific affect on the central pain mechanism itself. In fact, there is evidence that the tricyclic antidepressants do have an analgesic function separate from their antidepressant function. The antidepressants also facilitate sleep and allow discontinuance of sedatives which may be contributing to the client's morbidity. Most investigators report some response in the pain client to the antidepressants with suggestion that those substances blocking serotonin uptake are preferable.

Tricyclic antidepressants and phenothiazines in combination are reportedly effective in chronic pain problems. Specific indications are in postherpetic neuralgia, diabetic neuropathy, and in other central pain states involving deafferentiation. Again, the mechanism is unclear and often the pain returns when the medication is stopped. Amitriptyline and fluphenazine are a combination often used. It is in similar situations that anticonvulsant agents, such as carbamazepine, have been utilized.

Biofeedback and Self-Regulation Techniques:

Biofeedback techniques use instrumentation to provide the client with information about changes in bodily functions of which the person is usually unaware. Self-regulation techniques (e.g., hypnosis, autogenic training, meditation) are also used to help the client control internal physiologic states.

In pain states, anxiety and attention variables affect reported pain. It is possible to modify these factors with electromyogram (EMG) and skin temperature biofeedback training and through the

use of relaxation techniques. In some clients, these adjuncts facilitate pain reduction and promote sleep. They are **self-help techniques** that encourage the client in dealing with persistent pain.

Pain Management Programs:

Comprehensive pain programs have as their goals the intention to help the client and family cope with pain more effectively, to reduce the intake of medications, to teach self-treatment methods, and if possible, to reduce nociceptive pain. Both in- and out-patient settings are utilized.

In most psychologically.oriented programs, treatment consists of the following components: behavior modification, physical rehabilitation measures, medication management, education-cognitive therapies, group discussion, relaxation techniques, family member participation, and supportive psychological treatment.

Usually **the behavior modification techniques are the most controversial** component of such treatment programs **and require the most experience to have them applied in an effective way.** Such techniques typically include: (1) **Approaching pain behaviors, both physically and verbally, with a neutral response. In response to defined chronic pain complaints, the staff members say nothing, change the subject, or leave the room briefly.** Obviously, this approach must be carefully explained to the client and his or her family before admission. Subtle, adversive responses can develop in the staff and this requires monitoring as such staff behaviors are pain-reinforcing. (2) **Reinforcement of increased physical activity, independent** functioning, and social interaction. (3) Further reinforcement by graphing techniques of the client's physical achievement. (4) Reinforcement of improved functioning by the client's review of videotapes. (5) Provision of pain-related medications on an as-needed basis during the evaluation phase (usually three days) and at fixed times thereafter. This eliminates the p.r.n. patient-staff interaction which is felt to be a pain reinforcer. (6) Administration of pain-related medications in a vehicle which makes the patient unaware of the dose. This again requires careful explanation of the type of drugs to be used and the reduction schedule followed, emphasizing that prevention of physical complications (e.g. serious drug withdrawal) is assured.

Such a treatment program involves a multidisciplinary approach. Specialized psychological training must be provided to nurses, physical therapists, and occupational-vocational therapists. Physician colleagues also require explanation to avoid misunderstanding about treatment goals. If a complicating condition occurs, the operant program is suspended temporarily while any new problem is evaluated. This interruption requires clinical judgment as symptom substitution is a common problem in the chronic pain client.

Not all chronic pain clients benefit from this type of program. Admission criteria should include: (1) Medical and psychiatric evaluation. (2) A pain problem of six months' duration or longer. (3) No related malignant disease or progressive destructive peripheral process. (4) No specific medical, surgical, or other psychiatric treatment applicable. (5) Acceptance by the client of the treatment program. Each treatment program staff must make a decision on whether clients with active litigation should be accepted.

These programs are designed to help clients start over, psychologically and physically, in coping with their pain. In a way, **the goal is to "wall off" the pain complex that has assumed domination in their lives.** Accomplishing this **requires that the clients abandon a sick and passive role and make decisions** regarding their functioning and relationships based on their own priorities, preferably priorities that acknowledge their pain and limitations but keep these limitations in the background rather than allowing them to dominate their life.

It is only rarely that the chronic pain client is cured. Usually, it is a matter of managing a problem of indefinite duration. The chronic pain client can be helped by a variety of the above mentioned modalities. While it is not a dramatic area in which to work, most counselors are accustomed to the restricted and moderate therapeutic results achieved in other conditions with which they are involved.

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QUESTIONS BASED ON THIS LESSON

13. Which of the following statements is correct?

A. Psychiatric intervention has proved very successful in the vast majority of clients afflicted with chronic pain

B. The "Gate Control Theory" omits the role of central processing in the brain in modulating transmission of pain

C. The endorphin system is one biochemical finding in support of an internal analgesic system operative via central integrative processing of pain stimuli

D. Psychological influences do not affect how a client experiences and deals with chronic pain

14. Which of the following items in the evaluation of a chronic pain client *most* strongly suggests that psychologic components play a significant role?

A. Worsening of the physical disease causing pain

B. Absence of clinical depression

C. Past history of contact with mental health professionals

D. Accumulated evidence of repeated negative examinations, unsuccessful surgical procedures, or treatment failures

15. In the evaluation of a chronic pain client:

A. It is useful to have the client estimate the severity of pain on a scale of 0 to 10

B. Histories of chronic or recurrent medical problems in childhood have absolutely no bearing on the present problem

C. Test instruments, such as the MMPI, the McGill Pain Adjective Checklist and the Hamilton Depression Scale, are useless

D. Family history is completely irrelevant

over, please...

16. Which of the following statements is correct with regard to clients suffering with chronic pain?

A. Anxiety has little or no effect on the client's experience with pain

B. Minor tranquilizers should never be used in conjunction with analgesics

C. Antidepressant agents should only be used when there is evidence of severe Major Affective Disorder, depressed

D. Tricyclic antidepressants combined with phenothiazines are reportedly effective in certain cases, especially pain due to postherpetic neuralgia and diabetic neuropathy, among other conditions

Directions in
Rehabilitation
Counseling

VOLUME 2 • LESSON 5

Vocational Rehabilitation in Traumatic Brain Injury

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EDITOR'S NOTE

Many more people who have sustained head injuries survive today. Most TBI patients are young males between ages 15 and 24. Most suffer mild injury, but 10% have moderate and 5% severe brain damage. In this lesson, the author outlines the proper steps to be taken to assess such patients for vocational rehabilitation and to initiate and carry out effective programs. He stresses the need for a carefully delineated plan, the creation of which draws from many sources of information, including the patient's work history, transferrable skills, cognitive impairments, personality strengths, and the like. The most important element in successful job placement is to find the right fit. On-going evaluation and coaching or supervision are equally important. Due attention must be paid to behavioral and emotional problems that arise, such as a client's denial of his or her disability, premorbid personality conflicts that are commonly aggravated by the injury, and symptoms of post-traumatic stress disorder.

Introduction

It is estimated that **between 500,000 and 1.5 million Americans sustain brain injuries annually, with the largest incidence of the injury occurring in young men between 15 and 24 years of age.**[1] Recent studies supported by the National Institute of Disability and Rehabilitation Research[2] suggest **80-86% of those entering vocational rehabilitation demonstration projects were young single males with approximately a high school education. Alcohol and substance abuse issues were common within this population.**[3]

The survival rate for traumatic brain injured clients has grown dramatically in recent years thanks to improved emergency room procedures, treatment that includes tracheotomies and evacuation procedures at the emergency scene, and the use of automobile seat belts. The number of service provider agencies identified by the National Head Injury Foundation for this population has grown from a handful in 1980 to more than 600–which is a conservative figure. Three federally funded research and training centers in head injury and stroke continue their efforts at New York University, the University of Washington, and Baylor University. More recently, regional head injury center projects have been funded by the Rehabilitation Services Administration to improve the quality and coordination of service provision at regional sites around the country. Coordinating sites include the Rehabilitation Institute of Chicago, the Texas Rehabilitation and Research Institute at Houston, Mt. Sinai Medical Center in New York, and Craig Hospital in Denver. The National Head Injury Foundation, which is relocating to Washington, D.C., has been one of the fastest developing nonprofit consumer groups and presently has affiliates in 44 states.

Biomechanics of Traumatic Brain Injury

Traumatic brain injuries can be penetrating (open) or nonpenetrating (closed). Penetrating injuries tend to involve gunshot wounds, with the resulting impairment being more localized; in nonpenetrating, or closed, brain injuries, the damage is caused by the impact of the head hitting another surface, which results in the brain being bruised or contused at the point of impact. This can occur by the force of the blow itself, or by movement of the brain about the bony ridges near the temporal and frontal lobes in the forward portions of the brain. Other brain impairment can occur through the brain's shifting in the skull due to the impact and damage to brain tissue occurring on the opposite side from the point of impact (a contrecoup effect). Other more widespread damage (diffuse axonal injury) occurs through other twisting movements of the brain within the skull caused by the injury's impact, or secondary results of the injury such as anoxia (lack of oxygen to the brain), intracranial pressure, swelling (edema), or bleeding (hemorrhage).

A Perspective on Severity Level:

Two scales are commonly used to assess the severity of the injury and the patient's capacity for daily functioning. The Glasgow Coma Scale (GCS), developed by Teasdale and Jennett,[4] is a 15-point standardized instrument for assessing a patient's overall neuropsychological response. The scale assesses the patient's abilities relative to eye opening (functional score levels 1-4), best motor response (functional score levels 1-6), and best verbal response (functional score levels 1-5). It is generally accepted that a Glasgow Coma Scale score of 13-15 at initial admission can be classified as mild, a score of 9-12 is categorized as moderate, and a score of 8 or below as a severe injury. **Glasgow Coma Scale scores are most helpful in documenting the initial severity of the injury.** For clients who are medically stable weeks or months after a severe injury, it is common for them to have a high Glasgow Coma Scale score but still be dealing with severe residual cognitive impairments from the injury. For purposes of rehabilitation, **the Rancho Scale can be more helpful in understanding a client's baseline functioning at rehabilitation program entry.** The Glasgow Coma Scale, however, is generally useful in understanding the injury's severity at time of emergency treatment. Clients with GCS scores below 8 generally present a significant rehabilitation challenge--the challenge becoming even greater with scores of 5 and below.

The Rancho Scale[5,6] contains eight levels from 1, a "generalized" level of functioning in which the client is still in coma, through level 8, involving a "purposeful and appropriate" client level of activity (i.e., the client is alert and oriented, able to recall and integrate past and recent events, is showing carry-over for new learning, etc.). A client is usually functioning at a Rancho level of 6 or above in order to be involved in meaningful vocational activity.

Mild Brain Injury:

Mild traumatic brain injury approximates 85% of brain injuries. Persons with such injuries generally have a brief (usually less than 20 minutes) or no loss of consciousness, post-traumatic amnesia of less than one hour, and/or a Glasgow Coma Scale of 13-15. These individuals often look normal under neurological exams, including electroencephalogram (EEG), computerized axial tomography (CT) scanning, or magnetic resonance imaging (MRI) assessment. **Subtle cognitive impairments can result from microscopic neuronal damage as a result of the injury.** As discussed by Binder,[7] however, **most of the rehabilitation within this group focuses on individuals with persisting symptomology weeks or months following the injury, including headaches, dizziness, irritability, anxiety, blurred vision, insomnia, easy fatigability, and concentration and memory difficulties.** Even though the majority of persons with mild brain injury are working at one year, they have persisting complaints.[8] **The rehabilitation focus tends to be on that "post-concussive syndrome" group who do not return to work or work with multiple persisting difficulties. They may be experiencing some cognitive deficits as well as post-traumatic stress or other emotional exacerbations** related to the incident or emotional reactions to their subtle cognitive deficits. They appear to have developed a syndrome in relation to the injury. **Their reasons for abnormal performance cannot always be clarified with neuropsychological testing**, and their cases can be frustrating, not only for rehabilitation counselors but for family members and others. They may respond better to more of a pain-treatment-program approach that includes behavioral treatment, group therapy, and work hardening. To date, however, treatment models have not been carefully delineated or evaluated.

Moderate Brain Injury:

Traumatic brain injury of this type involves approximately 10%

of all such injuries and is characterized by a period of unconsciousness, post-traumatic amnesia in the range of 1-24 hours, and/or a Glasgow Coma Scale score between 9 and 12. Those with moderate brain injury can experience **cognitive impairments** in diverse neuropsychological areas such as memory, abstraction, poor language capabilities, and other areas of cognitive inefficiency. **Emotional problems** can be exacerbated as a result of the injury to include lability, agitation, depression, lethargy, forms of denial of disability, and self-centeredness. At this more-severe level of injury, other system injuries, including **post-traumatic epilepsy, muscle spasticity, coordination difficulties, hemiparesis, and other visual and sensory difficulties** can become more apparent. The physiatrist can offer an assessment of some of these other injuries and areas of impairments.[9] Review of available studies indicate that **about two thirds of persons who suffer moderate brain injury are unable to work for a year or more after the injury.**[10]

Severe Brain Injury:

Approximately 5% of all traumatic brain injuries can be categorized as severe. Persons with such an injury experience a period of **unconsciousness for 24 hours or more, post-traumatic amnesia of 8 days or more, and/or a Glasgow Coma Scale score of 8 or below.** These individuals often have **diffuse and severe deficits in most, if not all, areas of cognitive functioning.** Consequently, their rehabilitation can be challenging. It should be noted, however, that **some individuals with Glasgow Coma Scale scores of 8 or below do surprisingly well in vocational rehabilitation.** In some cases, they seem to have had greater cognitive and adaptive abilities than most clients premorbidly, or sometimes Glasgow Coma Scale scores and other gauges of severity may be inappropriately recorded. **The natural return-to-work history, however, for persons with this level of severity appears to be 23-30%.**[11] Recent studies supported by the National Institute of Disability and Rehabilitation Research[2] indicate **return-to-work rates following specialized vocational rehabilitation efforts varied between 39% and 77%.** Consequently, vocational rehabilitation to include forms of supported employment can still be assistive in their return to work. **A major issue, however, is job retention**, which is discussed later in this lesson.

Eligibility for Services

If the vocational rehabilitation counselor is in the position of evaluating a client's eligibility for vocational rehabilitation services, **the Twelfth Institute on Rehabilitation Issues offers some guidelines.**[10] They include **the client's ability to participate, the stage of recovery, appropriateness of the services requested, and alternative sources of funding for service delivery.** When clients are not medically stable or are at a stage in which they continue to make rapid cognitive gains, it may be better to reevaluate them within three to six months in order to more productively engage them in vocational activity. If clients can participate in assessment activity, especially situational assessment, they are usually ready to begin services.

Some clients ask for specific types of services, including comprehensive computer interactive cognitive rehabilitation for which the vocational and community re-entry "values" have not been established. Using the computer-aided training example, particularly for clients with severe injuries, **it may be better to direct funding expenditures toward** community-based job coach training or selective placement efforts rather than using available funds in full-day cognitive rehabilitation treatment with no discernible vocational goal.

In a number of cases, alternate sources of funding need to be carefully considered in providing services, particularly for the counselors who are working within a state vocational rehabilitation agency. Clients may come to the state agency for all types of diverse needs and simply not understand that the core purpose of involvement with the agency is vocational in nature.

Cognitive Remediation

Cognitive remediation is a service frequently requested by a client from vocational rehabilitation counseling. Cognitive remediation can be defined as "...a set of strategies intended to improve the intellectual, perceptual, psychomotor, and behavioral skills of persons with brain dysfunction (p. 118)."[12] As discussed by Kreutzer, Gordon, and Wehman, cognitive remediation has involved such interventions as practice sessions using computer software, compensatory strategies for memory improvement, driver training programs, and comprehensive daily rehabilitation programs.[12] In consideration of the number of service products being offered at different levels of cost, it is challenging for the rehabilitation counselor to advocate a specific type of service unless the outcome goals can be clearly tied to a vocational purpose.

In considering the purchase of these services, the following general guidelines are offered by established experts in the field:[13,14]

1. Following comprehensive neuropsychological assessment, a written treatment plan should be developed that reviews cog-

nitive areas of asset and deficit and identifies specific vocational goals or those that are supportive of achieving specific vocational outcomes.

2. **The goals should be specified in functional terms within the areas of life functioning in which progress is to be expected.**
3. **Treated problem areas should be prioritized and coupled with a description of the environments in which the problems occur.**
4. The treatment itself should be carefully delineated in a manner in which it can be replicated, **change can be documented**, and duration of the treatment program correlated with achieving specified desired changes.
5. Treatment activities should be structured in order to **integrate the social and emotional needs with the cognitive treatment of the client**.
6. Problems with generalization can be minimized by **providing treatment in the environments in which the problem is actually to be treated** (e.g., problem solving deficits that occur in relation to an inventory work activity).
7. **Criteria for advancement to more difficult levels of treatment should be specified and eventual discharge criteria established.**

Although considerable emphasis has been on computer applications in cognitive rehabilitation throughout the country, a recent review by Levin indicates that, at best, the value of computer-assisted training seems to be supported by changes in test scores.[14] This author emphasizes that **much further investigation must be undertaken** in order to establish the relationship between specific training and functional outcomes. It is important to encourage further research, **but it is difficult to justify significant expenditure of funds on unfounded methodologies.** Compromises can sometimes be struck in which the client is actively involved in a job tryout or job-coached activity during the day but is provided with several hours a week of cognitive rehabilitation (computer assisted or otherwise) related to an area of deficit. Reitan has suggested three hours per week of remediation activity related to a salient area of deficit would be practical.[15] He emphasized the therapist should be present and is an integral part of the remediation process. **Some of the benefits of computer assisted training may simply be that it is enjoyable, reinforcing, and assistive in client confidence building.** Those are worthwhile benefits, particularly if they are available at a low or reasonable cost. For a comprehensive review of this area, the reader is referred to the Twelfth Institute on Rehabilitation Issues report[10] and the recent review by Levin.[14]

Vocational Assessment

Vocational assessment in those with traumatic brain injury involves more extended time periods than is usual in vocational rehabilitation. Because of the complex cognitive, behavioral, emotional, physical, sensory, and other concerns of more severely traumatic brain injured clients, **it is generally necessary to have more time and input from other allied health professionals** in order to maximize the value of the vocational assessment.[16] **Assessing a client's transferable skills can require one to four weeks. A basic evaluation in which initial job goals or new job goals need to be established can require three to**

four weeks. Following the establishment of initial vocational goals, an intermediate level of evaluation using paid or nonpaid work experiences in the community can require two to three months before the viability of job goals can be established. Such levels of evaluation are described in more detail in the previously referenced publication, but abstracts of these descriptions are presented as follows.

Transferable Skills Assessment:

As in other rehabilitation cases, transferable skills assessment consists of a review of prior job description and performance standards, a specific job analysis conducted at the prior job site in order to establish data related to the work's interpersonal demands, productivity, and quality or accuracy of the required work. Specific work samples are often used in order to assess the viability of return to work. This can be very important because of the complexity of variables that can affect performance, especially for those with more severe brain impairment. Computer searches and traditional occupational resources can be used in order to identify other jobs in which the client may be familiar with the job tasks or equipment employed. If residual skills cannot be established or another job located within the client's prior company, the client will enter a basic or short-term evaluation in order to establish new job goals. Some clients who demonstrate potential for using residual skills in a specific job may move directly into the Intermediate Evaluation phase in which the skills are further assessed within the community.

Basic or Short-Term Evaluation:

In order to establish initial job goals or new goals for an individual who cannot return to a prior job, this assessment, which takes about three to four weeks, is generally conducted. As part of the evaluation, **information from other allied health team members and reports from any other recently conducted evaluations (e.g., by the speech pathologist, physical therapist, occupational therapist, etc.) is carefully reviewed. The physical capacities evaluation is often very important for those who have had more severe injuries. Speech is often affected**, so evaluators need to be concerned about capacities for receptive and expressive speech, as well as evaluation of the pragmatics of a client's conversational interactions (e.g., ability to maintain a conversational focus, turn-taking, or voice tone). Other aspects of the short-term evaluation include **vocational interest assessment conducted with picture inventories for those with reading deficits, personality assessment using the Minnesota Multiphasic Personality Inventory 1 or 2 and/or the Millon Clinical Multiaxial Inventory, and assessment of basic academic capacities** (often conducted by a speech pathologist).

Other areas of assessment include **neuropsychological testing and evaluation of worker behavior and performance on relevant work samples.** Work samples are often used in order to determine how an individual may best learn or "potential" for job site training rather than rigidly adhering to evaluation of performance against general normative data. Neuropsychological testing is the cornerstone of the evaluation process in traumatic brain injury rehabilitation. **The typical batteries that are used include the Halstead-Reitan Neuropsychological Test**

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Battery,[17] and the Luria-Nebraska Neuropsychological Battery.[18] The McCarron-Dial system, a battery of neurometric and behavioral measures, is often used in the assessment process and sometimes in place of a neuropsychological battery when that is unavailable.[19] The author recommends the use of a standard battery in order that the rehabilitation counselor develop an expertise in understanding the relative strengths and assets of different clients as they relate to employability. **The Weschler Adult Intelligence Scale-Revised (WAIS-R) tends to be standardly administered with the battery.**

It is important that the neuropsychologist **stress assets versus deficits** in the neuropsychological assessment process. Many neuropsychologists are deficit oriented in their evaluations. That is certainly important, but vocational rehabilitation counselors need to know the specific existing abilities upon which they can build a vocational rehabilitation effort. It becomes even more important given limited timelines. The vocational rehabilitation counselor must ask specific questions of the neuropsychologist in relation to the client's functioning in certain work activity, and include a job description with the referral questions.

Because many of the clients who suffer severe brain injury are young and have no well-developed interests, it can be just as important to establish their work reinforcers (i.e., what about the work may be important to them). Some clients may need exposure to a number of work areas before specific job goals can be targeted. A community job coach or placement person may be appropriate for helping them gain this exposure.

The basic evaluation should end with the identification of

specific job goals, steps in the continuum to job placement that may be necessary (e.g., what will happen next in an Intermediate community-based level of evaluation), **barriers that may require intervention or compensation** (to include rehabilitation engineering consultation as necessary), **or the identification of clients who require continued vocational exploration because the job goal has not yet been identified.** It must be emphasized that **further vocational exploration should be intensive and not approached casually, because time is an important commodity** to the younger client and if exposure does not happen under the monitoring of the vocational rehabilitation counselor, it often never will. More information on the use of neuropsychological information in vocational planning and use of the rehabilitation engineer in traumatic brain injury vocational rehabilitation can be found in monographs by Uomoto[20] and Warren.[21]

Intermediate Evaluation:

This level of evaluation employs community work experience sites to further determine whether an individual can achieve a specific job goal, or whether the goal needs to be modified and refined. Situational assessment is the most important aspect of evaluation for those with moderate to severe injuries. For example, work experience sites that have been used within the University of Washington and private sector rehabilitation programs within the Seattle area include diverse hospital job sites, university work sites, work experience sites within federal agencies, work sites within community nonprofit organizations, and work sites within the private sector. The federal agency work experience program, described in Chapter 306: 11-2 of the *Federal*

Personnel Manual,[22] is particularly helpful. Although this work is unpaid, federal agencies can offer work assessment opportunities in diverse sites, particularly in urban areas, and a number of those experiences will convert into permanent job appointments. In the state of Washington, job tryouts are arranged for up to 120 hours within the private sector as a result of a special agreement between the U. S. Department of Labor and the state's Division of Vocational Rehabilitation.

Private, for-profit traumatic brain injury rehabilitation companies have developed separate nonprofit organizations or have actually added clients to the payroll in order to pay them and cover workers' compensation insurance while evaluating or training them in landscaping, housekeeping, food service, and other jobs around a facility. In some cases, these individuals are being paid as workers within area businesses while they are being evaluated or trained, as described in an affirmative industry model.[23]

With increasing severity of injury, it can also be critical to perform a job analysis, which includes such information as data relative to specific task activity, production and accuracy criteria, and specific interpersonal behaviors on the job. In some cases, once the vocational rehabilitation counselor or job coach has framed the necessary data to be gathered, the analysis can be monitored or recorded by the job site supervisor or a co-worker. **In other instances, a job coach will be needed** not only to record necessary data, but also to train the client in specific tasks, cue the client, recommend compensatory strategies, and educate co-workers relative to the client's specific brain-related deficits, such as a specific type of memory deficit. Goals of the evaluation are established relative to the identification of a transition point at

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which the vocational emphasis can move from evaluation to choice of a placement model. In order to gauge progress, evaluation meetings are scheduled on a weekly or biweekly basis and information is shared between the vocational staff member, supervisor, and the client and/or significant others.

Choosing a Placement Model

The goal of all the prior vocational evaluation activity is to reach a point at which an appropriate job placement model can be chosen for the traumatic brain injured client. Review of work done at the University of Washington Department of Neurological Surgery suggests a number of different models can be used in successfully assisting the traumatic brain injured client to work.[23] **The author[24] proposes a job placement decision tree in which the counselor considers the severity of the injury** (mild, moderate, severe) **and a number of salient client-related variables** (level and pattern of neuropsychological functioning), **prior work variables** (experience, complexity of job activity, natural support available in the work place), **financial status, and emotional/ interpersonal functioning** in choosing an appropriate model. In milder cases, a client may be counseled or coached back into the work world. In other cases, assistance is needed with a selective full- or part-time placement. **The quality of the job match for brain-injured clients is the most important aspect of the placement process.** This can involve intensive placement efforts by a placement specialist who has integrated the necessary data from a neuropsychologist, vocational rehabilitation counselor, and perhaps other allied health team members who played a role in the client's evaluation.

In a majority of cases for severely injured clients, some form of employment support will be necessary. In some cases, a one-to-one job coaching procedure, as developed by Wehman and colleagues,[25] is appropriate. In other cases, however, due to the type of job and its complexity (electrical technician, attorney, carpenter, etc.), a supervisor or co-worker is a more appropriate primary mentor or trainer. In some cases, the job coach may assist in framing the training paradigm or aid in developing compensatory techniques (symbol systems for those without verbal communication, pictorial cues to parallel the job task steps, etc.), but the on-site employer, supervisor, or co-worker is really the primary training mentor. In other cases, the job coach or rehabilitation counselor is only peripherally involved in the training program, as when the company trainer requests consultation.

In a recent publication, perspectives on natural supports in the work place and the use of co-workers as trainers are reviewed as they relate to traumatic brain injured clients.[26] It is a new area in vocational re-entry procedures for the traumatic brain injured, but it does show considerable promise. The referring rehabilitation program or facility, however, will continue to be involved as a consulting resource. The Americans With Disabilities Act of 1990 may provide further support in encouraging this direction.

Counseling and Rehabilitation Planning

More than with other disability groups, the traumatic brain injured population can require expanded rehabilitation planning time lines. Cognitive, behavioral, and other system injuries can make such cases highly involved, but strategies for effective counseling interactions with this group have been reviewed in several recent publications.[23,27-29] **One of the biggest areas of difficulty is emotional or organically mediated denial relative to areas of deficit.** In some cases, the client will be able to work toward acceptance through individual or group counseling involvement. In many cases, however, it can be more helpful to use the Intermediate level of evaluation that involves actual work experiences in order that job site environments provide the feedback to the client. The counselor is there to assist in identifying a new direction or a less complex level of activity in the same job area if the client cannot perform (even with a job coach or other aids). In this manner, **the counselor becomes more of an ally to the client in dealing with the difficulties that the environments present and does not get locked in conflict or become polarized from the client. Direct confrontation, however presented, can often be less effective than the community job tryout or work experience.**

It has also been our experience **that awareness of cognitive deficits may be less important at lower level unskilled or semi-skilled jobs, but becomes more imperative at higher levels of vocational functioning.** In addition to compromised awareness, **other common difficulties include memory deficits, problem-solving impairments, difficulty in conducting multi-step operations, and a general loss in cognitive efficiency. Counseling interactions should be very concrete, using simple sentence structures, and should capitalize on neuropsychological information in order to best reach the client** (e.g., using visual/spatial material to emphasize a point rather than solely language). **Having clients take notes in relation to assignments and also repeat or paraphrase these activities can also be assistive in**

task completion. Finally, it can be helpful to "accentuate the positive" while allowing clients the time to absorb any feedback relative to their cognitive deficits. It has been the author's experience that **sensitivity in presenting deficit-related information and allowing sufficient mourning time can be very important** while continuing to make proactive rehabilitation steps.

In general, traumatic brain injured clients at the severe levels tend to profit more from **therapy styles that are more directive, including rational/emotive, cognitive behavioral, and reality types of approaches.** In order to improve generalization, group forms of psychotherapy and behavioral intervention are recommended.

There is also a traumatic brain injury client subgroup with premorbid personality disorders that would have required accommodation within the work environment even without the onset of the traumatic brain injury. Traumatic brain injury can exacerbate some of the these individuals' premorbid personality difficulties and also result in increased anger, depression, anxiety, and social withdrawal. A careful job match can assist in the accommodation of some of these issues, such as minimal or short-term people-contact jobs for clients with pre-existing antisocial personalities. **Pharmacological treatment is helpful in a number of cases** as an adjunct to behavioral treatment for clients with significantly disruptive behaviors.

Post Employment: Long-term Stabilization Effort

One of the major issues in the field of traumatic brain injury rehabilitation is job maintenance. **The job match between the client's areas of cognitive asset and deficit, interpersonal strengths, etc., as**

previously discussed, can be critical. It is highly beneficial to spend a considerable amount of time in the job goal setting and matching process in order to improve job stabilization. Results from three demonstration projects supported by the National Institute of Disability and Rehabilitation Research[2] suggest **a second placement was very common in these vocational rehabilitation efforts.** Wehman and associates[25] suggest that in order to better examine stability, **a monthly employment ratio** might be used in which percentage of months worked 20 hours or more across the months actually available for work is determined. West and Hughes recommend that **when a client is placed, different levels of follow-along contact be established.**[30] These include a *level one*, involving two contacts per week with client and employer; *level two*, involving one contact a week; and *level three*, a minimal involvement being one contact every two weeks. West and Hughes also review a number of factors that can be considered in establishing a desired level of follow-along services. **These factors would include the point from job stabilization, history of difficulties incurred during the job site training phase, changes in a client's medication or health status, quality of supervision and job duty fluctuations, the idiosyncratic behavioral characteristics of a client, the amount of obtrusiveness tolerated by an employer, and evident periods of personal crisis for the client.** If a client does not have long-term supported employment available, some type of post-employment monitoring schedule should be established in consideration of the above factors.

Evaluating Vocational Services in Post-Acute Rehabilitation

In serving this population, the rehabilitation counselor in private practice or the public sector vocational rehabilitation counselor can be in a position to purchase vocational rehabilitation services for a brain injured client. **In choosing a service provider, a number of considerations should be kept in mind.** The initial area of concern is *programming* considerations. **Does the service provider use some type of uniform vocational goal setting procedure? Are there articulated steps to successful placement and an emphasis upon situational assessment?** Because job retention is such an issue in this field, **what type of follow-up system is used and who is responsible for follow-up?**

In relation to the personnel providing services, **well-trained vocational rehabilitation counselors and supported employment job coaches should be available.** Because an inexperienced counselor will often have a difficult time in this field, **considerable rehabilitation counselor turnover is common.** How long has the vocational rehabilitation staff been in place? If new to the job, do they have prior traumatic brain injury experience or at least experience with a severely disabled population? In consideration of the complexity of these cases, it is very important that jobs are stable within the vocational services personnel ranks–continual turnover is not a good sign. It is important that personnel are available who actually have community job placement experience. Sometimes vocational evaluators have limited experience in this area, which affects the quality of their recommendations, especially with a traumatic brain injured population.

Finally, it is important to **evaluate the vocational outcome of the vocational service providers. What percentage of their clients enter the work force?** Perhaps more importantly, **what percentage enter new jobs?** It can be challenging to assist survivors in returning to prior positions. It can be more difficult, however, to place a significant proportion of clients in new jobs. As discussed earlier in this lesson, it can be more difficult to assist severely brain injured clients in re-entering or entering the work force. In order to assess a program's quality, it can be helpful to review with the staff the steps they use in assisting some of their severely injured clients to enter or re-enter the work force.

The above are offered as general guidelines for the reader's consideration. Staff youth, enthusiasm, and commitment can compensate for experience deficits; but the above need to be carefully assessed.

Conclusion

This study guide has been written to emphasize issues that are most germane to the vocational rehabilitation counselor. For a more comprehensive perspective, the reader is directed to the new text by Kreutzer and Wehman[31] which is globally focused on community re-entry issues, or the text by Rosenthal and coauthors[32] as a general reference in traumatic brain injury rehabilitation. The 1980s witnessed an explosive growth in service and the development of new treatment models in traumatic brain injury rehabilitation. It is hoped that the '90s will emphasize prevention of these types of injuries (anti-drinking and driving campaigns, car air bags, etc.) and evaluation/refinement of the service models that are currently in place.

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QUESTIONS BASED ON THIS LESSON

17. Which of the following statements pertaining to vocational rehabilitation of TBI patients is correct?

A. It's not necessary to assess transferrable skills

B. The quality of the job match is one of the most critical aspects of the placement process

C. Patients should never be employed at any job in a group that has anything administratively to do with the rehabilitation organization

D. Only the deficits reported in neuropsychological testing have any relevant meaning

18. TBI patients:

A. Never deny their limitations

B. Are best approached with blunt confrontation about their functional deficits

C. Should never be given psychopharmacologic agents

D. May demonstrate emotional and behavioral problems related to premorbid personality difficulties or as part of a Post Traumatic Stress Disorder

19. To which of the following factors need a vocational rehabilitation counselor give ***least*** consideration in choosing a vocational service group to work with TBI patients?

A. Uniform vocational goal-setting procedures

B. The organization's history of results in working with such patients

C. Whether or not computers are used as part of the program

D. Trained personnel experienced in working with TBI clients

over, please...

20. Which of the following scales is most useful in understanding the post-acute rehabilitation baseline in TBI patients?

A. Rancho Scale

B. Glasgow Coma Scale

C. Rorschach Test

D. MMPI

Directions in
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VOLUME 2 • LESSON 6

Resistance to and Fear of Change

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EDITOR'S NOTE

The framework within which each counselor views the distress and the conflicts with which his or her clients are struggling clearly influences the kind of therapeutic alliance that will be formed and the success or failure of the treatment enterprise. In this lesson, the authors give us a somewhat different perspective on the issue of resistance to change. Traditional, psychoanalytic theory has viewed resistance as an inherent obstacle to gaining insight or modifying values and behavior in the direction of health. As such, it is something to be identified, confronted, and resolved. But this concept carries with it a negative connotation: that resistance itself is a detrimental influence and should be removed.

However, what if resistance to change serves another purpose, one that is, temporarily at least, life saving? Many clients, at the point at which they reach out for professional help, are experiencing a threat to the way in which they have viewed themselves and the world around them. The structures that they have assiduously erected to deal with many fundamental life issues are coming apart. Their realization that they are undergoing a form of "dying" often activates a powerful reluctance to let go of the only meaning in life that they have known.

There are certain obvious components to our "self-structures." We are embodied. We are finite. We are capable of acting or not acting. We have choices. We are each separate from but related to other people. These elements synergize with each other, and they also thwart each other. Choice enables action, but, at the same time, choice may be limited by finiteness and impeded by lack of power or competence.

Counselors must keep in mind that, when clients resist change, they are often being threatened by loss and fear of the unknown. How we view what they are experiencing is as important, if not more so, than the specific tactics we may employ on their behalf.

Introduction

The fear of change is familiar in psychotherapeutic and psychoanalytic literature, where it is called the "resistance." Freud was not the first to point out what each counselor discovers: The client who comes desperately seeking help soon seems to try to defeat help being given.

When counselors begin their careers, they are apt to see this resistance as directed against them personally and against their efforts. As they mature in their craft, they come to recognize how much more significant is this apparent obstinacy. It turns out to be the way clients act in their lives at large. Indeed, counselors soon realize that this interview resistance is composed of the very patterns that disrupt the clients' lives and are the core of the problems or neuroses that bring them to therapy. It is this keystone recognition that gives counseling the power to affect clients' lives. (Thus Freud insisted that no psychoanalysis exists that is not the analysis of the resistance.)

Astonishingly, this is still not the end of the chain of significance. It is this further importance of the resistance that is the point of this presentation.

In brief, we propose that the resistance is not solely that which blocks our clients' full living; it is also what makes it possible for them to have the lives they do lead. Admittedly this is not the traditional view of the resistance, but we will show the values of operating on this hypothesis. We propose:

> **In order to live out one's life, one must come to some kind of definition of who one is and what is one's nature, and one must similarly define or structure the nature of the world in which one lives. These same definitions or structures which make life possible also limit it and keep one in self-defeating, repetitive patterns of being.**

A parable will convey more graphically what is proposed here. In shock, a man wakes to find himself swimming in the sea. As far as he can see in any direction there is no landfall or vessel to guide his efforts. Anxiety enters his veins. He treads water, tries to swim in one direction, but fears he may be only circling. He begins to tire; no relief seems likely. Fear mounts toward panic.

Then a blessed sight: a more solid shape a short distance away. Renewed, he swims to and soon grasps a plank. Gratefully he half-rides, half-swims, looks for more flotsam, and soon ties a hatch cover to the plant. Slowly--with great struggles at times, with fortuitous ease at others--the man collects and puts together what he finds until eventually he can climb out on his crude raft and rest.

When a squall hits, parts of the raft are swept away, but as the squall passes new gifts arrive from the sea. Now the man builds a more stable vessel.

In time other castaways float by on their rafts, and they merge constructions until the vessel becomes larger and more dependable. At times great storms wreck it, but it is possible to rebuild adequately.

As days turn into years, the children of the raft laugh at legends of how the rafts came to be. They are sure they know reality: The big raft on which they live is "the world," and they are certain that their lives on it are the way lives are really meant to be.

Structuring Our Lives

The allegory reminds us that **the structures within which we live our lives are, at root, our constructions. They have been assembled from whatever was at hand**, they sustain us with varied effectiveness, and they remain vulnerable to stresses that may come from any quarter. Characterizing them by no means says that they are without significance. Quite the contrary, this structuring of ourselves and our world is one of the astonishing and unique expressions of human capacity. **Humans create an overworld of meaning which is superimposed on the world of direct experience** in which other animals apparently dwell. From this meaning world, we transform the immediate world–for good or for ill.

A Clinical Example

A case synopsis illustrates how threats to our self-and-world structures may bring about excessive fear of change.

Todd is 53 years old, has an advanced degree in electronic engineering, is married, and has two children, ages 18 and 23. He is section chief in a middle-sized but quite successful research and development company. He has been in twice-a-week counseling for eight months. In an exchange with his counselor he tells of driving aimlessly and carelessly on the freeways the previous evening.

> "I'm not sure why, but I think I just kind of flipped out. I know I wasn't really there. Shouldn't drive when I'm like that. Though I don't know whether I've ever been like that before. Anyway, I was shut down on all systems–or at least, most all. Some way I kept enough going not to kill anybody or...."
>
> "Or...?" (softly).
>
> "Or myself," (flatly).
>
> "Mm-hmmm."
>
> "It was kind of like being dead, or partly dead."
>
> "Like being dead."
>
> "Yeah, but not really that either. At one point on the freeway I thought of just shutting my eyes and letting the car go without looking, but it was just a thought. I mean, I don't think I would

really do that."

"Not really."

"But driving the way I was.... That was sort of.... Well, I remember thinking, 'It's up to fate.' It was like being partly asleep but still sort of awake."

So **why is Todd playing Russian roulette on the freeway? In simplest terms, Todd is fighting off the awareness that he is changing. He believes that if he lets that awareness really take hold, he will cease to be**. Within his own experience, Todd is fighting for his life, yet he considers killing himself. What a paradox! Still, that is just what Todd is doing, and it is what many of us do–although, to be sure, not always as overtly and explicitly. **Todd is acting out his fear of changing. Yet, ironically, he entered therapy in order to change. When one feels that identity and the known world are in danger of being swept away, it is truly terrifying. The price of preserving the familiar world and one's place in it may be literal and physical death,** but that price has been paid repeatedly by men and women throughout human history.

The Nature of Life Structures

We will describe one way of conceiving the nature of the life structures that constitute our identities and the lived world. How we interpret the amazing and embracing fact of being is inevitably a product of who and where we are at the moment of interpretation.

The flotsam from which we build our rafts consists of what Rollo May calls our "destiny"[1]: the particular epoch, culture, family, and other conditioning and forming influences of our birth and life span. These provide materials from which we create the structures to meet the ontological circumstances of being human.

That formidable phrase, "the ontological circumstances of being human," means that we have come into different worlds depending upon our destinies (as we have just defined that term). Yet back of these differences lie certain constants or "givens" which all humans must deal with in some fashion. These are the ontological givens of being human.

It is convenient to identify arbitrarily five "givens" of being[2] which each person must take into account in some way:

We are embodied. Our lives are expressed in physical bodies.

We are finite. We are limited in what we can do, what we can know, how long we will live, and in all dimensions.

We are capable of acting or of not acting. We are not passive observers but are, rather, active agents in the creation of the actual from the potential.[3]

We have choice. Unlike the tropism- and instinct-governed species, we have the capacity to select from repertoires of possible responses.

We are each separate from but related to all other humans. Never are we wholly isolated, never wholly in union.

The Parameters of Being Human

These five conditions of being--embodiment, finitude, action, choice, and separate-but-relatedness--form the parameters of our being human. Although it is helpful to distinguish them as in Table 1, it is also essential to recognize that in reality they are five aspects of a unity. Thus, for example, finitude conditions each of the other four: Our lives are expressed in or through bodies that will live but a time. We

can act or not act but only within certain limits. While we have choice, there is much that we cannot choose. Love may bring us close, but oneness eludes us; hate may divide us, but we can never, if we are truly aware, deny all kinship with our enemy. In the same way, each of the five parameters interweaves with each of the others.

TABLE I
The Existential Conditions of Being

"Given"	Confrontation	Need/Value
Embodied	Change	Spiritedness
Finite	Contingency	Identity
Action-able	Responsibility	Potency
Choiceful	Relinquishment	Meaningfulness
Separate-but-related	A-partness[a]	Relatedness

[a] in the sense of being a part of yet apart from.

In some fashion--more implicitly than consciously--each person interprets the meaning of these givens of being. These interpretations are implicit, lived-out patterns. For example, **we have no alternative but to be embodied if we are to be physically alive** (although Todd is beginning to question whether we will continue to accept that equation). **Some center their attention on this dimension, as in those preoccupied with having a "glamour" image; some ignore it, as does the stereotypic, successful businessman who drives himself to a heart attack before he is 50; and some attack the body, as do the ascetics who practice mortification of the flesh**.

The existential parameters not only set the stage upon which we play out the dramas of our lives, but also form the underlying life motivations that animate our actions. This comes about because **each of these givens confronts us with a life issue with which we must continually deal in some fashion**. Similarly, each requires us to form certain perceptual structures in order to maintain and live out our lives. Table 1 offers estimates of these confrontations and their parallel existential needs.

The Existential Confrontations

In a crude way, the confrontations that arise from these conditions are equivalent to the waves that both support and threaten the riders on the rafts. From them emerge the possibilities of constructing our lives. **As we construe the fact of being able to act, for instance, we deal with the issue of being responsible for what we do or do not do** and discover our own powers and their limits.

Now, what is the point of all of this? The point is that **these needs are truly existential and are as vital to life as safety from threats, food, drink, and reasonable protection from excesses of heat and cold. Unless we have some degree of spiritedness, identity, potency, meaningfulness, and relatedness in our lives, we literally grow weak as persons, and we are likely to become mad, sicken, or even die.**

Our clients come to us because the life structures they have created–the timbers, rudders, and sails of their rafts–**are not sustaining them**, are not sufficiently satisfying their existential needs. **These structures are how they view themselves in their worlds, the patterns they have developed for seeking satisfactions and avoiding harms, and the expectations they evolve for how their lives should be.**

This last point is so important to the understanding of the resistance to change that it must be emphasized that we are not using metaphor or hyperbole when we speak of a "death." **When one has lived until the present moment with certain images of who one is and what one may expect in life, then the realization that these images are false and will never be realized is a "killing" recognition.**

The Need/Value Structures of Being

The existential issues with which our being confronts us require some response. These are termed needs/values in Table 1. It is necessary to examine these more fully. Each of us needs a degree of spiritedness, energy, and drive or motivation, and that need, rooted in our bodily being, is evoked as we confront the ever-changing world.

We live in a contingent universe in which we are affected by events beyond our anticipating or control. Our best efforts may succeed or fail; our deepest fears may be realized or not. We are so clearly finite in the midst of infinity, and how we deal with that fact constitutes much of our inner sense of identity. "I am a Christian...an atheist...a hard worker...a physician...." All such statements tell how a person sees himself or herself and something of how that person meets the circumstances of life.

The sense of potency is vital to our sanity. The person who feels totally impotent is the one who may go on an insane shooting spree. **We insist on having some power in our lives**, and we will do anything necessary to get it. To be able to act is to have responsibility for our actions.

Choice, the miracle of our evolved consciousness, inflicts the

endless burden of relinquishment, of having to say "no" to possibilities, of having to kill possible selves. Out of our choices we create meaning, and our meanings guide our choices. Meaninglessness is more fearful than the emptiness of space.

Finally, **we need a network of relationships with others**. Human beings are as much social organisms as they are physical organisms. Solitary confinement is one of the most dreaded punishments, and extended, unsought solitude can lead to madness or death. Even those who choose to be alone soon populate their isolation with fantasied others--real persons to whom they write, imagined persons who torment or support them, divine persons whom they serve. We are each inexorably separate from others but equally unredeemably bonded to others.

A return to Todd will illustrate these points. Todd learned in his early years that he was brighter than most of his schoolmates, that learning came easily, and that recognition and rewards followed promptly. He learned to expect that he could continually advance in any competitive situation. Although he probably would never have said it aloud even to himself, **he anticipated attaining the very top ranks in his profession and the very fullest satisfactions in his personal life. However over the past five years, the realization has been seeping into Todd's awareness that he is probably at or near the high point of his career, that others are able to go further, that his marriage and family are not exceptional, and that he, while certainly competent and a good friend and family member, is not the special person he had secretly thought himself to be**. In short, Todd is on the verge of discovering that the person he has believed himself to be does not--and never did--exist. This is, in subjective terms, a kind of death.

Implications for Counseling

The most important implication of what is being advanced is also the most difficult to convey, because in a way it is something that is already familiar. The point is that **perceptions of the client's "resistance" as opposition to therapy, neurotic, or something which must be overcome, analyzed away, or circumvented are themselves contratherapeutic. Such perceptions of what is undoubtedly one of the most central and universal phenomena of counseling repeatedly confound the therapeutic work, undermine the therapeutic alliance, and prolong the therapeutic course**.

For many counselors, this will not be a surprising statement. They have known that the old way of conceiving our task has been faulty. Yet we who write this after many years of immersion in our work know that implicitly we too often still tend to cast the counselor as the opponent of a negative force in the client.

Our well-being, our lives require that we maintain a measure of continuity in our way of living in the world and that we develop a repertoire of skills for responding to our existential needs. We cannot do so, we cannot remain sane, if we do not modulate our accessibility to the countless injunctions, seductions, inducements, invitations, and teachings of family and friends, the media, pulpit, and classroom, and every other facet of our lives. Counselors must find **ways of supporting their clients' capacity to maintain continuity** and must avoid efforts to undermine it.

Points for Counselors to Ponder

We offer three observations that counselors may consider as they engage in their work.

When the client resists change he or she is demonstrating that a threat to being is experienced. Understanding it that way, we need to accept the appropriateness of this defense and to join the client in seeking to **identify what is being threatened.** Although the words will be unique to the individual, the five existential needs described above offer useful directions for exploration.

The stance that the counselor takes in displaying to the client how the latter wards off change is, in itself, exceedingly important. If it is evident that the counselor is not invested in the client's giving up what he or she feels so strongly that he or she must have, then the counselor is experienced as an ally rather than an opponent.

It is important for the counselor continually to demonstrate to the client the professional's genuine conviction that the client can protect what is truly needed while relinquishing what threatens or cripples the client's life. This strong affirmation of the client's potency does much to support the latter's own readiness to move toward change.

It is evident that **the three suggestions are basically directed toward how the counselor conceives his or her role in relation to the life structures and their persistence.** Far beyond any techniques or stratagems, **the crucial contribution of the counselor resides in his or her attitudes, empathy, and faith in the client's own latent growthfulness.**

Summation

We humans fear change because it appears to threaten the

very structures that we take to be our lives, not just the structures that we think support our lives. Because we so see these structures, the possibility of their changing is the possibility of death. And there is truth in this apprehension.

To change is to kill, to die. To change is to relinquish one way of being--one identity, one life that might have been. To relinquish is to kill one possible self.

Nearly every day we are confronted with small choices of this type. For example, because one of the authors chose to write this lesson at a particular time, he was not able to attend a professional meeting to which he had been invited; on the scale of a day's activities, it is all too familiar and not particularly threatening choice, although, even in such matters, consequences remain unknown and unimaginable.

But larger changes--to change one's way of being alive, one's concept of who and what one is, one's view of the world--can be more sweeping and more frightening, inevitably involving potentially serious relinquishments. And relinquishments are deaths. For example, because one of the authors chose to become a psychotherapist she did not have the large family she had once dreamed of mothering. Because of an earlier choice, certain roads are forever closed.

Relinquishing the self one has always thought oneself to be is a kind of suicide. If one is strongly invested in that identity--as most of us surely are--physical death may not seem to be too high a price to pay to preserve (or to seem to preserve) who one thought one was.

George A. Kelly once commented, "The key to human destiny is the ability to reconstrue what cannot be denied." **When we counselors come to consider changing our way of regarding our clients' fear of** and resistance to change, we may find that we, too, are confronted with our own fear of change.

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QUESTIONS BASED ON THIS LESSON

21. According to the author, a patient's resistance is often rooted in:

A. Early childhood fixations

B. Unconscious hostility

C. Fear of forfeiting a structure that gave meaning to life

D. Paranoid pathology

22. What are the cited ingredients of "being"?

A. Finiteness

B. Capacity for action and choice

C. Separation from but relation to all others

D. All of the above

23. In the case history in the lesson, what crisis did the patient seem to be struggling to face?

A. Divorce

B. The death of a child

C. The realization that, because of heart disease, he has only six months to live

D. Middle age and the necessity to give up his former image of himself a being headed "for the top"

over, please...

24. In the management of a client's resistance to change, the counselor should:

A. Emphasize the neurotic, pathological nature of resistance

B. Stress how self-defeating the client's reluctance is

C. Actively seek deep unconscious explanations for the resistance in all cases

D. Empathize with the client's dread, identify what is threatening and help the patient find some kind of continuity as he moves ahead

Directions in Rehabilitation Counseling

VOLUME 2 • LESSON 7

Hope

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EDITOR'S NOTE

Clinicians are keenly aware of the clients' feeling of hopelessness as a central part of depression and as an obstacle to recovery. However, seldom do we concretely formulate its opposite: hope. Yet hope is one of the strongest catalysts for cure and a major motive to participate in whatever treatment program is indicated and proposed.

What is hope? To begin with, hope is realistic, seeking and directing itself to find something possible and attainable. It is sustained by a sense of relatedness to real persons. It involves imagination. In simple terms, hope involves the ability to identify one's legitimate wishes and needs and to discover a course toward their fulfillment.

According to the author, hope is learned from experience, a point of view reminiscent of Erik Erikson's scheme of perceptual learning that takes place during childhood development, centers on the mother-child relationship, and is reinforced or negated by later life events. To hope, one must be able to envision future. Hopelessness is born of a loss of faith and trust in future, not infrequently the consequence of excessive expectations that can never realistically be fulfilled.

The need to restore hope is seen most clearly among depressed clients who, having suffered a serious personal loss, must now reconstruct their lives and create new relationships, new sources of gratification, or new opportunities for achievment. Offering basic reassurance--i.e., reassurance rooted in the counselor's empathy, his or her ability to distinguish between pathological conflicts and constructive aspects of the client's personality, and skill in enabling the client to regain command of himself and his environment--is a critical element in the stimulation of hope.

The Nature of Hope

Years ago, Karl Menninger[1] wrote that hope was of central importance to the practice of psychiatry. **The first and most important characteristic of hope is that it is realistic. It seeks, directs itself to, strives for, imagines, and finds the real.** The direction of hope to the real is central to its understanding and its psychology. Hope imagines the real, in Buber's phrase, and it does not give up imagining the real. Moreover, the real that it imagines is the real that is not yet--that it grasps as **possible and attainable. Hope is directed to and sustained by a sense of relatedness to real persons.** Hope is, therefore, an act of mutuality. It is an act of shared imagination--or **imagining with. The loss of hope lies in the loss of capacity for shared imagination and its replacement by private imaginings. Hope seeks recognition of and by others.** It is an act that builds and is **sustained by community**.

Another important aspect of hope is its relation to desire--or, in other terms, wishing and wish-fulfillment. The link is a strong one. **Part of the capacity to hope is to identify and recognize one's wishes.** As Lynch[2] puts it, "When I cannot wish, I am moving toward despair." Yet if hope is rooted in wish-fulfillment and desire, it is not limited to these aspects of instinctual endowment. If hope reaches backward to the sources of instinctually-based desires, it also must reach forward to attain realizable and realistic goals and objectives. **It is the function of hope, therefore, to integrate wishes and impulses for gratification with real possibilities**.

Thus, hope has a reality focus that draws it beyond mere wish-fulfillment. It is not merely a vehicle for the expression of wishful fantasies, but **it is an adaptive resource of the ego.** It is not merely a defense against feelings of depression or despair, but a resource for effective and realistic coping.[3] Desire is the expression of wishfulness. It does not translate itself into real terms without the intervention of effective and purposeful action and intention. This is exactly the difference that separates wishing, and its associated desires, from hope.

The interplay between wish, fantasy, desire, and their integration with purposeful activity takes place at the heart of any creative work. In one aspect of its function, therefore, hope shares in the ego's capacity to regress constructively. In sodoing, it allows and **enables the ego to recapture the sources of imaginative potentiality and creativity.** It serves the ego's adaptive purposes by focusing and integrating instinctual derivatives with real possibilities. Thus, hope is liberalizing: it frees and channels man's creative and imaginative capacities.

Hope, therefore, involves fundamentally a sense of the possible, whereas hopelessness means essentially to be ruled by a sense of the impossible. Without this sense of being able to set and attain goals, there is no movement, no action, no motivation. Stotland[4] concludes that **accomplishment, achievement, or the attainment of future goals are impossible without hope, without the conviction that such goals can really be reached. One must have a sense of what is possible, what the limits of one's capacities and capabilities are, and what the extent of objective possibility is.**

Thus, hopefulness must in some degree be learned through experience. One must learn the conditions of objective possibility--the limits of possibility imposed by the structure of reality--as well as the limits of subjective possibility. Along with this, however, **one must gather the reinforcement of experienced success** in undertaking anticipated goals and achieving them. The rudiments of the basic experience reach back to early levels of childhood, as we shall see, but they continue through development to levels of adult experience. They contribute to the development of a sense of competence and of capacity.

As long as hope fails to adapt itself to the limits of the real and the really possible, it becomes no longer hope but enters the realm of the wishful. **As long as it entertains wishful anticipations and expectations that are not possible to attain or realize, it immerses itself in hopelessness.**

The Development of Hope

The development of hopefulness starts at the beginning of life. **Erikson[5] has remarked that hope is the earliest and the most indispensable strength that inheres in the very fact of being alive.** Hope is, therefore, a basic quality of experience that begins to be achieved in the first strata of the infant's experience of interchange with the world. The primary focus of that interchange in the first stages of life is in the interaction and exchange that takes place between the child and the mothering figure. **In the healthy mothering situation, a pattern of mutual responsiveness and sensitivity is set up in the interaction between mother and child that enables the child to build a sense of trust and reliance on the availability and responsiveness of the mother and in the assured inner capacity in himself for regulation of distressing inner states.**

While the element of trust enables the child to establish secure confidence in the needed and vital other, the element of hope enables the child to reach beyond that primary relationship. The

child's future growth depends critically on his emerging capacity to separate himself from the secure union with his primary objects. His capacity to do so depends in part onthe assurance that in the process of separating he does not lose the needed support and relation with the object. The child's emerging hopefulness and capacity for hope depends on this capacity to renounce prior dependencies and attachments in order to commit himself to future possibilities.

The aspect of this complex of loss and restitution that determines whether the restitutive effort will be directed toward reality rather than toward fantasy is hope. The adaptive and coping effort necessary to deal with losses that injure the self requires a response of the ego that intervenes in the libidinal economy and directs it to real restitutive objects. The detachment of libido from a lost object will tend, of itself, to follow the principle of pleasure and immediate gratification--thus leading in the direction of cathecting inner (hallucinatory) objects. An adaptive reinvestment in reality requires the modification of this process by the reality principle. Hope makes this reinvestment possible. It redirects psychic potentialities and energies toward real possibilities and locates the potentiality for restitutive gratification in the real order.

At each stage of development, the resolution of conflicts between the wish to remain dependent on powerful providers and the inner impulse toward greater independence and autonomy requires the exercise and direction of hope. Hope is thus the ego's capacity to imagine and retain a sense of future real possibility in the face of infantile fears of loss and abandonment. **At each stage in the developmental process, the need to master and to gain a capacity for mastery of developmental tasks, the capacity to tolerate painful affects of**

depression and anxiety, the potentiality for relinquishing passive dependencies for more active and autonomous positions--all essential to the successful accomplishment of the developmental process--**hinge on the capacity to envision in realistic and realizable terms the availability and possibility of future and desired states of existence and functioning.**

Hope and Hopelessness

Nietzsche, in his consummate cynicism, remarked that, "Hope is the worst of all evils, for it prolongs the torment of man." But as any psychiatrist knows well, man's hopefulness is not his torment; it is rather his loss or failure to hope that torments his soul. Man loses hope and becomes hopeless by way of defect. **He withdraws from hope by a failure to wish, to desire, to strive, or to plan. He also becomes hopeless by way of excess, by clinging to expectations that are beyond the limits of what is realistically possible. It is the burden of man's omnipotent expectations that prolongs his torment.**

A healthy sense of hopefulness is clearly not the same as the euphoric or manic repression of a sense of loss and despair. In contrast to such manic denial, hope is based on the capacity for mourning and on an accumulation of past experiences of such successful mourning efforts. Hope emerges out of the matrix of disappointment, disillusionment, and despair through the successful acceptance and integration of loss. Hope springs out of loss, therefore, as an essential component of the ego's restitutive effort to recover what has been lost and to set itsface toward a more hopeful future. **Hope,** therefore, **is an essential component of the restitutive aspect of the loss complex.**[6]

Hopelessness embraces a sense of futility, a sense of the unattainability of goals and purposes regardless of activity. What needs to be done seems to stand beyond one's capacity to perform or achieve. The client is trapped and checkmated. His watchword is, "I can't!" or "The world won't let me!" **His perspective of the world and of himself is immersed in impossibility.** Basic to this position of hopelessness is the perception of oneself as unworthy, inadequate, unacceptable, valueless. This perception is based on a fantasy that provides the basis for an inner core of self-perception. **One often sees clinically depressed clients who persistently maintain a view of themselves as worthless and devalued, not only in the face of a lack of confirming evidence but often in the face of overwhelming evidence to the contrary.** The sense of inner conviction of worthlessness carries on independent of any influence of reality. The inner sense of evil means that the individual cannot perform good acts, cannot set useful goals, and has no right to hope or strive, because what it produces must bear the stamp of its origin: worthlessness and evil.

This pattern of internal organization has been described in psychoanalytic terms by the functioning of a primitive and punitive superego. The superego functions in a harsh, critical, and devaluing manner and is conceived as the agency of internal self-deprecation. By way of the superego, infantile sadism andhostile destructiveness are directed against the self so that depression, guilt, and self-devaluation are the result. This may affect the individual's behavior as well, so that internal dictates of the superego are lived out in a variety of forms of self-defeating and self-destructive activity. It is as if the superego's claim that the person is worthless and evil serves as a mandate which is then acted out--a self-fulfilling prophecy of self-defeat and self-degradation. This process is an operative mechanism in many forms of mental disturbance and mental illness. The severity of the self-destructive wishes may reach the point of suicidal wishes and action. In seriously sick and psychotic people, the power and destructiveness of these instinctually derived forces are often overwhelming.

Hopelessness is related to the individual's subjective estimate of the probability of achieving certain goals.[7] Plans and goals seem to be out of joint. Goals may be sought and striven for long after any realistic expectation of their fulfillment is past. Plans may be restricted merely to immediate short-term goals and to the exclusion of any long-term purposes. The expectation of hope is that plans of action will reach and achieve anticipated goals. Hopelessness expects failure, so planning is futile and meaningless. **The disjunction of plans and goals and the feeling of hopelessness are most characteristically found in depressed clients.** They form the central and basic theme of depression. The clients are overwhelmed with a sense of purposelessness and futility.

The depressive person is afflicted with a sense of hopelessness and helplessness. **He believes that his skills and capacities are inadequate to achieve the goals he has proposed for himself,** that his failure is due to his own inner inadequacy and incompetence, and that his previous attainments or accomplishments are meaningless and without value. He has a sense of helplessness, of dependency on others for any attainment or gratification, and of being foredoomed to futility in any exercise of his own resources.

The picture in the sociopath is somewhat different. **The**

sociopath believes that his own capacities and plans have little to do with his attainment of future goals. He sees others as interfering with any of his attempts to reach goals, and thus others are to blame for his frustrated lot. Any attempt to set goals that would be perduring or long-range is foredoomed to failure. The sociopath thus finds himself in a chronic state of hopelessness that permits little future orientation. He escapes this feeling of futility by seeking his rewards and gratification in the present, with little regard for the future.

A particular manifestation and expression of hopelessness is boredom. Boredom carries with it a sense of purposelessness, meaninglessness of things, lack of interest, apathy, and general disinterestedness. It is the death of wishing. It may mask itself in forms of hyperactivity and hypomanic flourishing--forms of pseudowishfulness and pseudohopefulness--but **boredom is substantiatially a withdrawal of cathexis from things and objects in the environment. The withdrawal and the cessation of wishing are essentially narcissistic. Boredom is an expression of the sense of entitlement that places the responsibility for stimulation, interest, attraction, and involvement on other agents besides oneself.** It is a disappointment with the world, a reaction to the denial of expectations, a falling out of love with reality.

Hope in Counseling

The achievement of a hopeful attitude is a central ingredient in any counseling success. Study of the counseling process over many years has returned again and again to a common motif, namely, the importance of gaining and sustaining a sense of hopefulness in the treatment of clients. Some years ago, for example, Martin[9] had discussed the role of reassurance in therapy. I would regard reassurance in this context as being equivalent to the engendering of a sense of hopefulness in the client. **Martin distinguishes several forms of reassurance: (a) false reassurance, (b) superficial or defensive reassurance, and (c) basic reassurance. False reassurance often takes the form of expressions of confidence, faith, encouragement, and support in response to the client's attitudes of self-devaluation and self-hatred.** While this approach can be understood as part of a countertransference reaction, **the client more often than not continues to maintain his sense of self-devaluation and self-disparagement even more strongly. Raising of false hopes for levels of recovery or functioning that are beyond the client'scapacity draws the client away from realistic goals and into an illusion of hope that will lead only to further hopelessness and even to despair.**[10]

Defensive reassurance takes the form of an effort on the part of the counselor to restore a failing neurotic defense when some of the underlying anxiety, depression, or other pathological affect begins to show itself. This sort of "back to normal" superficiality often goes unacknowledged and may serve as a rationale for short-term interventions.

The form of reassurance that is most realistic and most hopeful is **basic reassurance. This more productive form of reassurance expresses itself in the counselor's humane and understanding approach, in his affective involvement with and acceptance of the client, in his ability to maintain a sense of discrimination between the client's pathological conflicts and symptoms and the more mature, constructive, and healthy part of the client that has the capacity of**

entering into a meaningful and collaborative alliance and engaging with the counselor in the counseling.

The beneficial results of counseling seemed to include as one of the important components an activation of the client's expectations of improvement. As a rule, **greater improvement is found when the client was able to attribute his improvement in some degree to his own efforts rather than to some outside agent. The response to counseling is related to the extent to which the client saw himself in control of his environment rather than controlled by it.**[11] Thus, a central element in the effectiveness of all forms of counseling is that they strive toward **mobilizing the client's resources and eliciting a sense of hopefulness** that the process can help him deal with his difficulties, and that his difficulties can be effectively dealt with and resolved.

Conclusions

Man develops hope in other men even as he derives help from other men. The initial roots of hopefulness are laid down in the interchange and mutual regulation and responsiveness of the child and his mother.[8] The generation of hope requires the trusting dependence on another human being. Therapeutic context requires and intends such a real contact between man and man. Clients find countless ways to avoid the reality of the counselor, but the therapeutic action and the genesis of hope rest on the basis of a real relationship between counselor and client. When the client discovers that his sense of disappointment, despair, and hopelessness can be shared with another **empathic** and understanding person, hope springs into being. The sharing of such painful and vulnerable feelings opens the way to a deeper sense of relatedness to another that draws the client away from his sense of alienation and less-than-human isolation.

The client's hopelessness can offer many objections to the efficacy or utility of the process, but engagement in it sets the stage for a process of immersion in reality, which is never all-or-nothing and which engenders the frustration of working through many complex elements piece-by-piece. The therapeutic processboth builds and requires a capacity to tolerate delay and the postponement of effective and satisfying results. **Hopelessness does not want to take a limited next step and to keep on taking next steps--it wishes to leap to the final result. Therein lies its impossibility. Only in taking the next step does the client find and achieve a sense of the possible.**

The reality in and through which this resolution is immediately attained is the relationship with the counselor. In attaining a meaningful contact with the counselor, the client begins to turn from sickness toward health, from alienation toward social involvement, from narcissism toward realism, from hopelessness toward hope. In counseling, the client must not only find a basis in the reality of his relation with the counselor, but he must find sufficient trust in the counselor and in the process to enable him to delay his wish and to continue to work toward therapeutic goals. **Clients often come to the treatment process with magical expectations of cure or with peremptory demands for instant relief from their anxiety or depression. The beginning of hope for them is synonymous with the willingness to wait, to tolerate the unavoidable delay, and to set their sights on distant goals for which they are willing to work.** By accepting these limits of the reality and possibility of the therapeutic process, they are beginning to surrender mere wishfulness and willfulness and are becoming more attuned to and accepting of reality--the reality of themselves, of the limitations of the treatment situation, and--perhaps most significantly--of the limitations and lack of omnipotence of thecounselor. To the degree that we offer our clients the possibility of becoming truly human, we offer them the rudiments of hope, the sense of real and human possibility.

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QUESTIONS BASED ON THIS LESSON

25. Hopefulness is:

A. Always lost in states of depression

B. A unique personality attribute that is inherited and not dependent on learning

C. A learned experience, beginning with the earliest perceptions in the mother-child relationship and extending to later childhood and adult events

D. Not influenced by positive life experiences

26. Which of the following statements is/are correct?

A. Clinically depressed clients never maintain a view of themselves as worthless when confirmatory evidence is lacking

B. The depressed client never feels that his skills and capacities are inadequate to achieve his goals, and always attributes his failures to others

C. Boredom can be a manifestation of hopelessness

D. The achievement of a hopeful attitude in clients is only important in a few clinical situations

27. Defensive reassurance involves:

A. Restoration of failing neurotic defenses when underlying anxiety or depression emerge

B. Raising false hopes for levels of recovery and function beyond the client's capacities

C. Contradicting the client's expressions of low self-esteem

D. Empathy, the ability to discriminate between pathology and constructive personality features, and the skill to engage the client in the work of counseling

over, please...

28. Greater therapeutic improvement is obtained when the counselor:

A. Employs strategies involving basic reassurance

B. Helps the client attribute improvement in some degree to his own efforts

C. Mobilizes the client's resources toward realistic fulfillment

D. All of the above

over, please...

28. Greater therapeutic improvement is obtained when the counselor:

A. Employs strategies involving basic reassurance

B. Helps the client attribute improvement in some degree to his own efforts

C. Mobilizes the client's resources toward realistic fulfillment

D. Discourages magical expectations of counseling and encourages patience and the willingness to work for distant goals

E. All of the above

Directions in
Rehabilitation
Counseling

VOLUME 2 • LESSON 8

The Management and Resolution of Dependency in the Depressed Client

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EDITOR'S NOTE

The problem of excessive dependency is by no means restricted to clients suffering with depression. However, most depressed clients manifest excessive dependency, either as a consequence of the immobilizing and self-diminishing effects of the depressed mood or as a long-standing personality trait that may have enhanced their vulnerability to depression. For example, the individual who has not sufficiently developed the ability to regulate self-esteem or to separate himself from his family of origin, who involves himself with persons who are more psychologically powerful than himself, and looks primarily to others to sustain his feeling of worth will obviously be more prone to serious depression if and when such involvements are threatened.

Handling the transient dependency of an acutely depressed individual is one thing; cultivating healthy dependency in the course of counseling with a depressed client is quite another, and it can often take months and sometimes years. The issues to be dealt with in counseling, the stance to be assumed by the counselor, and the tactics he can employ to deal with dependency effectively have been highlighted in an eminently practical way.

Theoretical Background: Dependence

It is unwise to present an account of the management of the depressed client who is dependent without first considering what dependence is and what relationship it bears to the state of being depressed. **It is generally assumed that dependence is commoner in women than in men, and this may be related to the increased vulnerability that women have to developing depression.** For grammatical convenience only, throughout this review the dependent person will be referred to as he or him.

What is Dependence?

Pathologically dependent people are frequently described as being childish,[1] and in a recent review[2] it was suggested that it is useful to think of a dependent person as if he were an adult behaving like a child. Parens and Saul[3] emphasized that **dependence is a normal feature of childhood. As maturity is reached it becomes less evident. Mahler,[4] however, correctly drew attention to Freud's assertion that a lifelong, albeit diminishing, emotional dependence upon the mother is a universal truth of human existence.** Dependence is a complex phenomenon and cannot be defined simply.[2] When pathological, it has the following characteristics: An excessive need to be loved, cherished, and made a fuss of; a general feeling of inadequacy and incompetence; a persistent need for guidance, reassurance, and approval; a tendency to take rather than to give; and an inclination to relate to others in a humble and apologetic manner from a lowly and submissive position.

One way to view dependence is as a failure of maturity, and any therapeutic approach to dependence should involve the facilitation of further maturation. Essentially the excessively dependent person has failed (1) to adequately separate initially from his mother and subsequently from his family of origin, (2) to establish a well-defined and secure identity, (3) to acquire an approving and nonjudgmental internalized parent and–in consequence appropriate sense of self-worth, and (4) to consider himself to be worthy of joining the world of adults and to believe himself to be on equal footing with other adults.

How is Dependence Created and Maintained?

It seems likely that the dependent person has failed to attain an adequate level of maturity because he has not been encouraged or permitted to do so by his dominant maternal figure and other members of his family of origin. If he remains in contact with her or with them, she or they will continue to play a part in maintaining him in his present dependent position. In terms of transactional analysis, as described by Berne,[5] he has a well-developed child ego state but a deficient adult and parent. He can therefore only relate to others as would a child to a parent. He needs to induce other adults to adopt a parental attitude towards him. Millon[6] has described how the dependent individual searches for a "single, all-powerful, magical helper" on whom he can project a parental image and in whom he can place his trust. Once such an attachment has been formed, there is little opportunity for change and the dependent position is maintained.

It should not be forgotten that there also exists a complementary personality type who needs to be needed and who prefers to play the dominant role in relationships.[7] In transactional-analysis terms, such a type has a well-developed parent ego state but a deficient adult and child. He seeks out people who will become dependent upon him and applies pressure on those with whom he relates to coerce them into assuming a more subordinate role. He finds dependent people attractive and they, in turn, are attracted to him. **If his need to be dominant is compelling, he may draw out latent dependent behavior even in relatively non-dependent people. That type of person is not uncommon among doctors**, nurses, psychiatrists, counselors, and even psychotherapists, and it can be a serious handicap in the management of dependence.

When treating a dependent client the counselor must consider: his own personality and attitudes towards the client, **the extent of the client's continued involvement with members of his family of origin and the effect that such involvement is having upon him, the personalities of other key figures in his life and how capable they are of modifying their style of relating to him, and the attitude and behavior of other professionals involved in his care.** Whatever good work maybe done in counseling sessions can effectively be undone by parents and significant others with whom he lives and has contact.

The Relationship Between Dependence and Depression

Bemporad[8] observed that **pathogenic dependency is perhaps the one characteristic of the depressive that has been unanimously emphasized in the psychiatric literature.** Fast[9] wrote of the intense feeling of total dependence on others that one sees in persons prone to depression. Bibring[10] referred to the "orally dependent type" who thrives on "oral narcissistic supplies," the lack of which he considered to be the most frequent type of predisposition to depression. Gaylin, in the preface to a collection of psychoanalytic papers on depression, wrote, "...there is hardly a theory of depression that does not in some way emphasize orality."[11] Rado[12] referred to depression as "a great despairing cry for love," and Fenichel[13] described the depressive as a "love addict" who is in a perpetual state of greediness. Millon[6] observed that **the dependent person's need for affection and assurance that he will not be abandoned may become so persistent as to exasperate and alienate those upon whom he leans most heavily. This only serves to increase his neediness.** When inevitably others reject him, a cycle of decompensation begins. Overt expressions of self-criticism, self-blame, and self-condemnation come to the fore and ultimately progress to frank depressive symptoms.

Research Evidence:

Bullock et al.[14] observed an intensification of dependent behavior by women when they were depressed. They wanted to be told what to do and have decisions made for them. The dependency took on a demanding quality, which was often a source of irritation and confusion to their husbands, who fluctuated between being overprotective and doubting their need for help. **It is of some interest that approximately half of the 57 items on the Dependency scale of the MMPI refer to aspects of depression, but those who score high on the depressive items also score high on the remaining items.**[15] Hirschfeld et al. developed a relatively depression-free measure of dependence[16] and demonstrated that **depressed subjects have significantly higher scores than normals.**[17] **Following recovery, their dependence scores**

dropped but still tended to remain significantly higher than those of never-depressed subjects.[18]

Self-Esteem: The Vital Link

Beck[19] observed that **the precipitants of depression are often situations which would be expected to lower self-esteem.** Hirschfeld et al.[20] proposed that a fall in self-esteem marks the onset of clinical depression and considered that **depression-prone people have a chronically low level of self-esteem** McCrainie[21] maintained that depressive affect is a direct response to lowered self-esteem, and Rado[12] considered that **those who are predisposed to depression are wholly reliant and dependent on other people for maintaining their self-esteem.** Chodoff[22] defined dependence as the degree to which a person's self-esteem is maintained more or less exclusively by the approval and support of other persons or their surrogates, and Nemiah,[23] explaining the onset of neurotic depression, described how the person who is abnormally dependent on other people finds himself in difficulty when faced with a situation that lowers his self-esteem. He pointed out that **the normal person who finds his self-esteem assaulted and diminished by various situations and events restores his emotional equilibrium by putting his setbacks into proper perspective, balancing a failure in one direction with success in another. The dependent person lacks those inner resources that would sustain him in times of adversity.** Storr[24] proposed that **the normal child acquires a kind of built-in self-esteem from an early positive relationship with his mother.**

The Powerful Other

Fast[9] described the depressed person's belief that he is helplessly dependent on another person (originally the mother) who is responsible for his present misery and the only possible source of rescue from it. **He sees his situation as one centrally involving rejection by the powerful other and himself as helplessly dependent on the other to reinstate him as good, acceptable, loved, and a part of meaningful life. Bemporad[8] referred to the dominant other as that person who gives meaning to the depressive's life. The depressive has ceased to respond to his own psychic interior and derives pleasure only from gaining the approval of the dominant other.** He has a fear of what Bemporad has called "autonomous gratification," seeking to please himself by becoming actively involved in rewarding activities that give him personal satisfaction. Instead, he enters into a "bargain relationship" in which he denies himself personal pleasures in return for nurturance from the dominant other.

Dependence and the Suicidal Inclination

There is both research and clinical evidence[25,26] that **suicide attempts are commonly made by dependent individuals.** Tabachnick[27] considered that the person who attempts suicide is often more than usually dependent in a rather infantile manner. Schwartz et al.[28] described the suicidal character type as that form of the generally dependent character type in which the suicidal threat or attempt is the specific device by which assistance is coerced from others. **The suicidal impulse appears strongest when a relationship to a significant other has broken down or is in danger of breaking down.** Draper[29] suggested that the ever-present "pain-in-living" of the suicidal adult may represent a re-experiencing of the inconsolable pain of the helpless infant, wittingly or unwittingly deserted by the mother in whom he has put "all his affection, libidinal hopes, and pleasures." Draper referred to the mother as "the ONE." The pain returns when the adult later encounters loss of the ONE in a selected transference object. "It is not difficult to see," he wrote, "the link between the loss of a vitally important person who has become draped (no matter what his actual sexual identity) with the powerful mantle of the first loving figure, the ONE."

Therapeutic Aims and Methods

Opinions vary on the importance of counseling in the treatment of depression. Bemporad[8] expressed the view that it is the most effective treatment of mild depression, and Arieti[30] maintained that, while the presenting symptoms of severe depression may be removed by nonpsychotherapeutic measures, the client remains vulnerable to further episodes without the adjunct of counseling. Because the counseling of depression needs to address a number of issues, the present review is artificial in that it is restricted to considerations of dependence, either as a manifestation of the depression itself or as a component of vulnerability to it.

Counseling

The Initial Contact:

The counselor's initial response to the dependent client will be determined by the client's circumstances and emotional state. **During a period of crisis, when a critical relationship has been broken or is**

under strain, pain-in-living will be intense.[29] The client will be inclined to regress and to cling desperately, and the counselor will have little option but to offer himself as an attachment object. This may even require physically holding him. **A desperately clinging client can arouse strong anxiety in a counselor** and acknowledgement of this should deter him from taking evasive action. For a while he will remain the client's reason for living. He should be respectful of this and avoid any action that may be interpreted as rejection.

Even at less critical times, the dependent client's persistent need for closeness can feel like an intrusion into the counselor's personal space, and the counselor may respond by being intolerant and hostile. Keeping these feelings in check, however, is a necessary requirement for successful counseling. Millon[6] observed that a dependent person tends to seek assistance whenever he can and is all too receptive to being involved in treatment. He is comforted by the strength and authority of the counselor and feels assured that he will provide him with the kindness and helpfulness he craves. **Bemporad[8] pointed to the seductiveness of the dependent client, whose praise and flattery can be a source of narcissistic gratification to the unwary counselor.** The client's care-eliciting maneuvers can at times evoke an overprotective and nurturing response, and it **is easy to swing too far in the direction of making promises that are impossible to keep.**

The Counseling Plan:

The object of counseling is to correct, belatedly, those maturational deficiencies that were enumerated under the definition of dependence. That requires a kind of rerun of the client's childhood, with the counselor inescapably taking on the role of alternative parent. Although the transient intense dependence of the depressed client is fairly readily resolvable, the correction of the persistent trait dependence of the depression-prone individual may require months or even years. Management of the separate components of dependence will be considered in sequence.

Love:

Since a number of writers have emphasized the hunger for love in the dependent client, particularly when he is depressed, it is reasonable to consider whether, and to what extent, the counselor should offer him that love he craves. It might be permissible, in moments of extreme crisis, to offer a direct and unambiguous show of love. In one such situation, Dublin wrote, "I will love the hell out of him."[31] Certainly many dependent clients recall that they did not experience their mother's love as unrestrained and freely given. Instead it had a forced and unreal quality. The conventional clinical detachment of the counselor may be perceived as frustratingly similar. It seems likely, therefore, that progress will be limited unless the counselor actually comes to like the client and within the safe confines of the counseling session permits, when appropriate, a show of genuinely caring feelings.

Separation:

Throughout the course of counseling two distinct, though interrelated, separation issues must be considered. The first is the separation from the mother and the family of origin; the second is separation from the counselor. To some extent the client's attachment to the counselor, albeit temporary, makes attempts at separation from the mother and the family easier. **The client must be helped to be more aware of the mother's devices for keeping him close to her. These may center on the issue of her needfulness of him,** with the mother inclined to play upon his sense of obligation and loyalty. **He swings from pangs of guilt over his wish to break free to outbursts of anger because she will not let him go.**

The client may still be living with his mother or be in regular contact by visit, letter, or telephone, so he should be encouraged to try various degrees of confrontation, which may be rehearsed or reported on during counseling sessions. **Some advantage may exist to inviting the mother to some of the sessions; there each may come to appreciate more clearly what it feels like to be the other.** The mother may resort to an all-or-nothing declaration--either he stays or he goes completely. **The prospect of a complete break can fill him with such anxiety that he will abandon his attempts to increase his separation. Alternatively, with the assured support of the counselor, he may choose and adhere to a complete break.** Such a drastic measure is a common resolution of the conflict. **If the mother is dead or out of contact, the process of more complete separation must be worked through entirely at a subjective level.**

Separation from the counselor can be no less difficult, and it may occur on the "micro" or the "macro" level. The client may be so concerned that he will lose the counselor that **he may try to extend the session beyond its normal length by introducing problematic material toward the end or simply by feeling unable to leave.** He may try to **telephone** the counselor between sessions to ask for **extra**

appointments or make suicidal threats or gestures. The counselor must make clear to the client how much time he can offer and try not to deviate from that. He must assure the client that he does care about him but will care neither more nor less in response to any manipulative maneuvers. At the "macro" level, the client will try to extend the course of counseling beyond its optimal length. The counselor must recognize that he may be the recipient of a powerful transference and must therefore gently ease the client away, allowing him the option of further contacts over a protracted period. It is always preferable for the client himself to take responsibility for the final break.

The Establishment of a More Definite and Secure Identity:

The establishment of a secure identity runs hand in hand with the process of becoming more separate. Staying close to the mother involves sharing her identity, just as staying close to the family involves sharing the family identity. Mahler[32] bracketed together the twin processes of becoming separated and becoming a separate person into the single term "separation-individuation." Bowen's differentiation of self from the family of origin carries the implication of breaking away and starting anew as a different person.[33] He referred to the "emotional stuck-togetherness or fusion" in the nuclear family and of the need for the individual to attain a state of emotional objectivity from his parents. That is equivalent to what others have referred to as autonomy. Ideal adult relationships develop between two autonomous individuals. A person who has not attained the state of individuation, differentiation, objectivity, or autonomy can only relate to another by fusion.

An important feature of the counseling of the dependent client is **helping him to develop the capacity to gradually build up an identity that is recognizably his own.** He should be encouraged to seek out that small nucleus of self that he does have and progressively add to it. To this end he should repeatedly be invited to **express his opinion** and to **make choices**. He should be offered an opportunity to **discover his likes and dislikes**, to **do those things he thinks would give him pleasure**, and to fully experience the pleasure he derives from doing them.

What makes this exercise difficult for him is the disloyalty he comes to experience either to his parents or to some other emotionally important person. Arieti wrote, "Step by step we must clarify to the client that he does not know how to live for himself. He has never listened to himself or been inclined to assert himself, but cared only about obtaining the approval, affection, love, admiration, or care of the dominant other."[30] The counselor must appreciate the fact that the client has, up to this point, lived only for the praise of others. He finds it hard to conceive of an existence in which his actions are motivated by his own sense of personal satisfaction. The transition from living to please another to living in response to inner needs may be accompanied by feelings of isolation, inertia, or futility. Having abandoned one life-style, he may experience a time-lag before he can establish a new one. **He may readily slip into a kind of pseudoautonomy in which he creates the impression of self-motivation in order to gain the counselor's approval.**

The Acquisition of Inner Resources:

It is one thing to establish a sense of self and quite another to develop an appropriate evaluation of that self. The dependent individual tends to be completely at the mercy of the judgments of those around him. He finds it difficult to tell whether what he says or does is good or bad. He must therefore extend his efforts at determining what he likes or dislikes to a level at which he ascertains whether he likes or dislikes himself and the things that he does. The Gestalt principle of urging him to accept and to own unashamedly everything that is part of himself, particularly his body, will have a powerful reinforcing effect. Most dependent persons believe themselves to be incapable of doing anything well. It is necessary for the counselor to point to the client's positive qualities and achievements and persuade him to acknowledge their obvious worth.

Counseling sessions usually reveal that one of his parents had a persistently disparaging attitude toward him and was grudging in praise or approval. It is important that he be made aware of this and helped to understand why this parent needed to behave in this way. It is impossible to totally expunge a bad internalized parent, but he should be helped to view the parent's behavior more objectively and be less influenced by the parent's former view of him. During the course of counseling the counselor will inevitably come to assume a parental image and his more positive view of the client will hopefully counteract the actual parent's negative view.

Enabling the Client to Accept Himself as an Adult:

It is reasonable that parents should make clear to their children the demarcation, within the family, between the older and younger generation, and the behavior which is appropriate to each. As children grow older they should be permitted gradually to assume a more adult status and eventually arrive at the level of their parents. For the dependent individual this gradual progression to adult status has been interrupted and he has become fixated at the child level. The situation is usually complicated by the fact that he has become involved in one or more relationships in which he plays out the role of the child to a dominant other, who reciprocally plays parent to him.

During the initial stages of counseling it will be difficult to be anything other than relatively dominant to a client who is behaving in a conspicuously submissive manner. The client knows no other way of relating and his belief that it is the counselor's job to solve his problems and make him better will not easily be dispelled. Bemporad[6] has argued that regression in counseling is definitely to be avoided, that the use of the psychoanalytic couch is not advisable, and that giving in to the client's demands may provide symptomatic relief but will not affect his underlying patterns of thought. Eventually, he warns, the client will demand more and more.

This is not necessarily so. When a client is in a depleted state, a limited period of indulgence, even to the point of regression, may be necessary to restore his emotional reserves. He will not necessarily demand more and more. The ultimate objective is, of course, to progress gradually towards a relationship in which counselor and client interact on an adult-to-adult basis. The strategies referred to in the previous two sections for establishing a strong identity, increasing autonomy, and improving self-esteem will obviously contribute to this. At the same time the counselor must increasingly decline to respond to the client's appeals for guidance and reassurance and instead treat him as though he were a competent and responsible adult.

The client may carry with him from childhood a deep-seated fear of growing up and a conviction that he has no right to behave as an adult. That emotional distortion is maintained by a powerful superego and a disapproving and punitive internalized parent. More superficial treatment approaches will fail and premature attempts to coerce him towards more adult behavior will be blocked unless this fundamental issue is confronted. A degree of controlled catharsis may be necessary, during which he will alternate between **self-punishing guilt and vengeful rage towards the suppressive parent.** Such emotion will be directed, through the transference, onto the counselor. Additionally, the counselor will present himself as an alternative, more benign parent, who will ease the client's emergence into adulthood.

In terms of transactional analysis, the client has come to adopt a dependent script which he is able to maintain by entering into relationships with others who are willing to play the complementary dominant role. He relies heavily upon his child ego state and his adult and parent ego states need to be built up. Dusay[33] observed that strengthening weaker ego states is like exercising an underdeveloped muscle. The client needs a great deal of practice and encouragement from others who must be prepared to abandon their own excessively parental behavior toward him.

Management of the Dependent Suicidal Client

The dependent individual experiences acute anxiety and intense psychic pain whenever his relationship to a supportive other person is broken or weakened. The pain may be such that it drives him to actual suicide; more often he only attempts or threatens it. Initially the suicidal attempt or threat will evoke an increased caring response in the supportive other, but subsequently it may come to have the opposite effect. When hospitalized or in counseling, the dependent individual may react suicidally to fears that the hospital staff or counselor does not really care. The caregivers in turn may respond by showing increased concern or by being more protective or restraining. This response makes the client feel frightened by their lack of trust in him and as a result he becomes helpless and even more needful of them. **Frequently, such a situation sets up a vicious circle in which repeated suicide attempts are followed by increasing concern and restraint.** Schwartz et al.[28] emphasized the need to **break this vicious circle by encouraging the client to take progressively more responsibility for himself.** They likened the situation to that of the overprotective parent who prevents the child from acquiring a confidence in coping with everyday hazards by not exposing him to them.

Involvement of Significant Others in Counseling

Outside of counseling the dependent client may be involved in a number of relationships that maintain him in his dependent attitudes and behavior. One of these may be the continuation into adult life of the relationship with his mother, or other parental figure, from which his dependency grew. **There may be at least one other relationship in**

which he has totally or partially reproduced this original relationship. For his own personal reasons, the dominant partner in such a relationship may prefer to remain dominant and resist the dependent person's attempts to be more assertive or self-reliant. Not infrequently two dependent people form a relationship and compete with each other for the dependent position. In all of these situations **there are advantages to drawing the significant other into the counseling sessions.**

The continuing relationship with the original parent, being of the longest duration, is usually the most difficult to change. The parent has an investment in keeping the client weak and needful and is not likely to see any advantage to allowing him to break free. Sessions that include the parent may, however, make it easier for the client--in the presence of the counselor--to stand up to and pull away from the parent. The counselor, by being supportive of the parent, may be able to help him accept this.

Counseling sessions with the dominant other are more likely to succeed. **The dominant other has two principal fears: one, that if he loses control, the relationship will get out of hand; the other, that if he relaxes his dominant facade he may find it necessary to reveal his own vulnerability.** The therapeutic objective should be to allow him to discover that the dependent partner is capable of acting responsibly without posing too great a threat to his own position in the relationship, and to reassure him that it is not too disastrous to expose his own weaknesses to the dependent partner, who may in fact sometimes welcome the opportunity to be caring and sympathetic toward him.

Relationships between two dependent individuals are

notoriously unstable. Each is afraid to allow the other to become too separate or too autonomous, and so each thwarts the other's efforts in these directions. Each feels unloved and yet resents the other's receiving any love. Such relationships sometimes assume sadomasochistic characteristics since the partners take turns to hurt or be hurt: when one is up the other is down. Suicide attempts by either partner are common. **For one partner, through counseling, to become less dependent spells disaster for the other. Ideally therefore each should be in counseling, but this should be supplemented by conjoint counseling.**

The essential strategy for attempting to modify the relationship with a significant other is preventing excessive anxiety in either member of the relationship. When anxiety is aroused by the possibility of change, each member will dig in and adhere even more strongly to his present role. Progress can be made by suggesting a series of small shifts in which one partner will agree to give way in one direction at the same time and to the same extent as the other agrees to give way in a complementary direction.[35]

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QUESTIONS BASED ON THIS LESSON

29. In depressed clients:

A. Excessive dependency always motivates caring and never exasperation among those on whom the client relies

B. Angry responses and rejection of the client always leads to a reduction in the client's dependency needs

C. Dependency may be the result of the helplessness associated with depression, or it may have set the stage for the depression itself, or both

D. Active counseling is contraindicated because of the risk of intensifying dependency problems

30. Which of the following statements is correct?

A. All clients who are depressed suffer with a chronically low level of self-esteem in their predepression personalities

B. Most depressed clients have previously been able to find self-reliance entirely from within

C. To react to a blow to self-esteem with a period of depression and distress is distinctly abnormal

D. The pre-illness personality of the depressive client is often characterized by excessive reliance on others to sustain self-esteem and significant difficulty recovering in a timely fashion to blows to self-esteem

31. In response to clients' dependency ploys, the counselor should:

A. Yield to demands for more time

B. Avoid any interpretations that may provide insight into the relationship between behavioral manipulations and dependency needs

C. Flexibly draw definite lines, making clear how much he can offer, sticking to those terms in a reasonable manner

D. Openly deny that he has any caring feelings for the client

over, please...

32. In treating the depressed, dependent client, one should:

A. Assume total responsibility for the timing of the end of counseling, without input from the client

B. Help him develop a stronger sense of self, express opinions, make choices, recognize strengths and limitations

C. Encourage him to feel disloyal and guilty whenever he moves to distance himself from dominant others

D. Show him how to win the approval of others at all times

Directions in
Rehabilitation
Counseling

VOLUME 2 • LESSON 9

Professional Ethics for the Rehabilitation Counselor

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EDITOR'S NOTE

The Code of Professional Ethics for Rehabilitation Counselors was updated in 1987 to reflect the evolving complexity of the practice of rehabilitation counseling in a wide variety of settings. According to this code, counselors "are committed to facilitating personal, social, and economic independence of individuals with disabilities," and owe their "primary obligation" to their clients. The Code consists of 10 general standards referred to as canons; under each canon are several "more exacting standards that provide guidance in specific circumstances."

Ethical counselors are expected to avoid any action that would harm others; respect the integrity and protect the welfare of people and groups with whom they work; serve as advocates for the disabled; act with integrity toward colleagues and institutions; observe rules affecting fee payments; observe clients' privacy and right to confidentiality; know the extent and limitations of their competence and practice accordingly; expand the knowledge and skills base of the profession; establish and maintain their own competence; and attend to their own mental and physical health.

Introduction

On September 25, 1972, the National Rehabilitation Counseling Association formally adopted the first "Code of Ethics for Rehabilitation Counselors."[1] The Code described in some detail "standards of practice [for rehabilitation counselors]. . . set by their colleagues and peers." It was drafted in response to the request of counselors who, when faced with various ethical dilemmas in their work, found no professional code to assist them in resolving their problems. Rehabilitation counselors realized that a human service "profession" which did not hold its members to an ethical code did not warrant the confidence and trust of persons seeking the services of such professionals.

Professionals operating without the constraint of minimally acceptable standards of behavior can manipulate and abuse their relationships with clients and fellow professionals and put their clients or patients in jeopardy. **The rehabilitation counseling Code of Ethics was intended to stand as an assurance that counselors who provided rehabilitation counseling services were indeed professionals with the knowledge and skills necessary to act in accord with and behavioral standards of the Code.**

Nearly 16 years later, the American and National Rehabilitation Counseling Associations and the Commission on Rehabilitation Counselor Certification jointly approved a new ethical code for rehabilitation counselors.[2]

More comprehensive and detailed than its predecessor, **the 1987 Code of Professional Ethics for Rehabilitation Counselors reflects the evolving complexity of the practice of rehabilitation counseling in public rehabilitation agencies, in private non-profit and private for-**

profit settings, and in private practice. Meeting the requirements of national legislation that expanded the educational and employment opportunities for persons with disabilities requires more-sophisticated knowledge and skills for counselors working in the public sector.[3-5] Counselors in the private sector often find they are called upon to reconcile a number of competing interests.[6-8] The Code notes that regardless of setting, ". . . rehabilitation counselors may be called upon to provide counseling; vocational exploration; psychological and vocational assessment; evaluation of social, medical, vocational and psychiatric information; job placement and job development services; and other rehabilitation services." The many human services offered by the profession of rehabilitation counseling require counselors to ". . . demonstrate adherence to ethical standards and. . . ensure that the standards are enforced vigorously."

Professional Ethics

Describing an individual as a "professional" suggests the person has a broad education, possesses highly developed skills and knowledge, is bound by the discipline of a standard of behavior developed and enforced by peers, and is dedicated to address the complex needs of those he or she serves.[9] Persons seeking the help of the professional assume they will receive benevolent consideration and competent service.

The codes regulating the practice of human service professionals have their origin in the Hippocratic oath, thought to be composed by the physician of ancient Greece who is credited with developing the principles of medical science about 400 B.C. The oath, sworn by

"Appollo the Physician and Asculaepius," regulated physicians' relationships with mentors and their families, patients, and other professionals, and committed them to a life of personal integrity. They pledged to keep information about patients confidential, abstain from doing anything which would cause harm, and refrain from improper relationships with their patients. Should they not possess the competence to deal with specific problems, they referred patients to other professionals.[10]

Ethical codes are meant to protect those who use the services of professionals by establishing standards of minimally acceptable professional conduct and by restraining professional power. Writing about business ethics, business commentator and management analyst Tom Peters noted ethical codes are "...above all about treating people decently...and [about] respect for a person's privacy, dignity, opinions, and natural desire to grow."[11]

Because rehabilitation counselors provide a range of services to their clients, often collaborating with professionals in other disciplines, they must reflect on the consequences and correctness of their actions and develop rules to govern their relationships with clients, peers, and other professionals. Their ethical code reflects in the main the concerns of the Hippocratic oath and the ethical codes of related human-service professions. It explicitly recognizes the professional status of rehabilitation counselors obliges them to practice at a level of responsibility and accountability substantially higher than that required of "nonprofessional" persons.

Code of Professional Ethics for Rehabilitation Counselors

According to their ethical code, rehabilitation counselors "...are committed to facilitating personal, social, and economic independence of individuals with disabilities." Counselors owe their "primary obligation" to their clients, defined as "people with disabilities who are receiving services from rehabilitation counselors." The code defines clients because questions have been raised about the primary relationship and loyalty of rehabilitation counselors in certain settings. Though the definition presents some problems, it is an attempt to clarify the counselor's primary relationship, particularly in those situations in which employing agencies may assert a conflicting claim on the counselor's loyalty.

Because the code has as its basic objective the promotion of public welfare by specifying and enforcing ethical behavior expected of rehabilitation counselors, it contains 10 "general standards of an aspirational and inspirational nature" referred to as "canons." Under each canon are several "more exacting standards that provide guidance in specific circumstances" that are called Rules. Canons are further described as "maxims which serve as models of exemplary professional conduct." They incorporate "the fundamental spirit of caring and respect which professionals share." Rules are derived from the code's canons, and represent applications of the canons to situations that rehabilitation counselors may encounter in the course of their work.

TABLE I

Canons of the Code of Professional Ethics For Rehabilitation Counselors

Canon 1

Rehabilitation counselors shall behave in a legal, ethical and moral manner in the conduct of their profession, maintaining the integrity of the Code and avoiding any behavior which could cause harm to others.

Canon 2

Rehabilitation counselors shall respect the integrity and protect the welfare of people and groups with whom they work. The primary obligation of rehabilitation counselors is to their clients, defined as people with disabilities who are receiving services from rehabilitation counselors. Rehabilitation counselors shall endeavor at all times to place their clients' interests above their own.

Canon 3

Rehabilitation counselors shall serve as advocates for people with disabilities.

Canon 4

Rehabilitation counselors shall act with integrity in their relationships with colleagues, other organizations, agencies, institutions, referral sources, and other professions so as to facilitate the contribution of all specialists toward achieving optimum benefit for clients.

Canon 5

Rehabilitation counselors shall adhere to professional standards in establishing fees and promoting their services.

Canon 6

Rehabilitation counselors shall respect the confidentiality of information obtained from clients in the course of their work.

Canon 7

Rehabilitation counselors shall promote the welfare of clients in the selection, utilization, and interpretation of assessment measures.

Canon 8

Rehabilitation counselors shall assist in efforts to expand the knowledge needed to more effectively serve people with disabilities.

Canon 9

Rehabilitation counselors shall establish and maintain their professional competencies at such a level that their clients receive the benefit of the highest quality of services the profession is capable of offering.

Canon 10

Rehabilitation counselors holding the Certified Rehabilitation Counselor designation shall honor the integrity and respect the limitations placed upon its use.

[From the Code of Professional Ethics for Rehabilitation Counselors (American Rehabilitation Counseling Association, National Rehabilitation Counseling Association, National Council on Rehabilitation Education, and the Commission on Rehabilitation Counselor Certification)]

Canon One:

Canon One declares rehabilitation counselors should discharge their professional responsibilities legally, ethically, and morally to maintain "the integrity of the Code" and to avoid any action "which would cause harm to others." Canon One's Rules -- among

other obligations – require counselors to "obey the laws and statues in the legal jurisdiction in which they practice," and "be thoroughly familiar with, ...observe, and discuss with their clients the legal limitations of their services...so as to facilitate honest and open communication and realistic expectations." For matters in which the Code conflicts with "legally mandated ethical and professional standards," counselors will regard legal mandates as governing their behavior. They are encouraged to make appropriate ethical committees aware of such conflicts. If no legal guidelines exist, counselors are to consider the Code as binding.

The Rules of Canon One explicitly prohibit "dishonest, deceitful, and fraudulent" behavior. Considerations of financial gain or personal benefit or the financial gain of employing agencies must not "...interfere with the exercise of sound professional judgment and skills." Rehabilitation counselors "...will avoid public behavior that clearly is in violation of accepted moral and ethical standards." When counselors are not in agreement with agency policies, they "...attempt to effect change by constructive action within organizations." Counselors are to resist participation in illegal or unjustifiable discriminatory employment practices or in employment practices "...inconsistent with the moral and legal standards regarding the treatment of employees or the public."

Canon Two:

Addressing the relationship between counselors and clients, Canon Two asserts the primary obligation of rehabilitation counselors is "...respect[ing] the integrity and protect[ing] the welfare of people and groups with whom they work..." and "...endeavor[ing] at all times to place their clients' interests above their own."

The Canon's Rules require counselors to communicate clearly to clients the purposes, goals, and limits of the counseling relationship. They proscribe misrepresentations of counselors' competence, the exploitation of counselors' influence, and dual relationships that "...impair professional judgments or increase the risk of exploitation." The Rules describe the limits of third-party relationships, underscore the necessity of informed consent, and recommend the termination of counseling relationships that do not benefit clients. They stress the need for close collaboration between counselors and clients and their families.

Canon Three:

Canon Three states, "Rehabilitation counselors shall serve as advocates for people with disabilities." The Rules encompass the counselors' obligation to promote access for persons with disabilities in "...programs, facilities, transportation and communication..." and to "...strive to eliminate attitudinal barriers, including stereotyping and discrimination, toward people with disabilities." They urge counselors to "...act as advocates of clients to ensure effective service delivery."

Canon Four:

Professional relationships are examined in Canon Four. Rehabilitation counselors must act with integrity in their relationships with organizations, colleagues, agencies, referral sources, institutions, and other professions to best serve their clients' interests. Rules of professional conduct for Canon Four specify how rehabilitation counselors should act as members of rehabilitation teams and the procedures they should follow for dealing with ethical violations of colleagues and other professionals. The Rules of Canon Four prohibit sexual harassment, disparaging the competency of other professionals and agencies, and the exploitation of professional relationships. They also address the responsibility of the counselor to "facilitate the professional development" of students and subordinates.

Canon Five:

With reference to fees and the promotion of services as a private practitioner, Canon Five requires rehabilitation counselors to adhere to professional standards. The Rules under the Canon forbid accepting fees or remuneration from clients who are entitled to the same services and benefits through an institution or an agency, except for situations in which clients have been fully informed about the availability of such services. The Code rules out rebates, commissions, or "other forms of remuneration" for referring clients to professional services. It stresses counselors' primary obligation to "...aid the public in developing informed judgments, opinions and choices."

Canon Six:

Canon Six requires counselors to "...respect the confidentiality of information obtained from clients in the course of their work," and sets out in some detail the extent and limits of the obligation to respect client privacy. Counselors must inform their clients at the beginning of the counseling relationship the limits of confidentiality. The Canon's second Rule is derived from the Tarasoff v. the Regents of the University of California decision, which holds counselors responsible for "...tak[ing] reasonable action, or inform[ing] responsible authorities, or inform[ing] those persons at risk..." when "...there is a clear and imminent danger to clients or others."[12] Counselors must notify their clients that such action has to be taken. The Rule advises counselors to consider violating confidentiality "only after careful deliberation" and consulting with other professionals.

Safeguarding the maintenance, storage, and disposal of clients records; preparing written and oral reports; and providing "germane" information to other professionals, families, and prospective employers are also actions addressed by the Rules of Canon Six. Counselors need permission in writing from clients or their legal guardians to give information about clients to other involved parties. The Rules also require counselors to ensure that agencies with which they have professional contact have defined policies and practices to protect client confidentiality.

Canon Seven:

Because the work of rehabilitation counselors involves the use and interpretation of a variety of physical, psychological, social, and vocational assessments, these activities must, according to Canon Seven, "...promote the welfare of clients." Counselors, therefore, must be aware that various tests require different levels of competence or expertise. They should know the limits of their competence and administer only those tests for which they are trained. Canon Seven's Rules also require counselors to be alert to the effect of ethnic, socioeconomic, disability, and cultural factors on client assessment but to guard against stereotypical interpretations. The Rules make special mention of the interpretations derived from computer programs and procedures, cautioning counselors to avoid assessment approaches that may be obsolete or easily abused.

Canon Eight:

Canon Eight states "...rehabilitation counselors shall assist in efforts to expand the knowledge..." necessary to provide more effective service for persons with disabilities. The Rules establish standards for the research activities of rehabilitation counselors, requiring them to ensure that research meet the criteria of validity and honesty and protect, when necessary, the confidentiality of subjects. The Rules place special emphasis on honesty and openness as "...essential characteristics of the relationship between rehabilitation counselors and research participants..." and on confidentiality, especially in the presentation of case studies.

Canons Nine and Ten:

The Code's final Canons, Nine and Ten, address the professional competence and credentialing of the rehabilitation counselor. Canon Nine obligates counselors to establish and maintain their competences at a level at which their clients receive the highest quality of service. The Rules of Canon Nine commit counselors to accepting "...only those positions for which they are professionally competent...," to professional continuing education and involvement in professional associations and meetings, and to dealing with personal problems and conflicts that interfere with professional effectiveness. Educators of rehabilitation counselors are to maintain high standards of knowledge and skill, making sure their instruction is accurate, up-to-date, and scholarly.

Certified Rehabilitation Counselors are obligated by Canon Ten to honor the integrity and respect the limitations of the designation CRC. The guidelines promulgated by the Commission on Rehabilitation Counselor Certification describe those limitations. Canon Ten and its Rules apply only to individuals who have received certification as a professional rehabilitation counselor as a consequence of having passed the certifying examination.

The Code's Limitations

Although ethical codes for specific groups of professionals in the helping services may be required to apply ethical principles to the issues and situations specific to a particular profession and to describe professional behavior that may differ from the demands of ordinary ethical behavior, they have their limitations.[13] They cannot address every possible ethical problem which may arise. The ethical principles they articulate may be inadequate to provide a basis for addressing a specific dilemma. Though they may embody general ethical principles and encourage ethical behavior, they cannot be considered anything but a description of what constitutes minimally acceptable competent and correct behavior for a specific profession. They cannot assure that a person seeking the assistance of professionals will receive excellent service from individuals of personal integrity and high moral standards.

The enforcement of a code's provisions presents substantial difficulties, and even the most satisfactory procedure for addressing complaints about ethical violations has major deficiencies. **Too often, professions are perceived as treating egregious ethical offences with something less than the severity they require.** Professional codes often address matters which are also concerns of parallel forums, especially the courts. Courts may nullify or substantially modify code requirements or, as in the Tarasoff case, impose new obligations.

Before the promulgation of the Code of Professional Ethics, rehabilitation counselors were forced to seek guidance from several professional codes, which differed from one another in their methods of resolving certain ethical issues. Because they were developed for and by other professions, they had little applicability to situations commonly faced by rehabilitation counselors. The Code of Professional Ethics for Rehabilitation Counselors was written to apply to rehabilitation counselors in all employment settings. It was designed to "preserve continuity with past standards of practice...[in] previously endorsed codes, particularly those of the National Rehabilitation Counseling Association, the American Association of Counseling and Development and the American Psychological Association."[14]

Although its adoption was a significant event in the professional development of rehabilitation counseling, the Code shares the limitations of all ethical codes, and it must not be regarded as the definitive description of ethical rehabilitation counseling. It is a basis for more detailed critical reflection and thinking. More than anything, the Code is intended to be referred to and used. Its relevance is to be tested in and by the daily experience of rehabilitation counselors.

Client Rights/Counseling Values

Beauchamp and Childress wrote that the principles of autonomy (respect for a person's right to make decisions affecting one's life), nonmaleficence (avoidance of physical or emotional harm to another), beneficence (active helping of another), and justice (fair treatment of another) are the basis of ethical codes and inform the process of ethical decision-making.[15] Those fundamental moral principles are reflected in the Code of Professional Ethics for Rehabilitation Counselors. They protect what Van Hoose and Kottler regard as basic client rights in the counseling relationship: informed consent, confidentiality, competent treatment, and other rights guaranteed by law.[16]

The Code commends several other moral values to rehabilitation counselors. Among them are **truthfulness, the intrinsic value of persons, respect for privacy, keeping commitments made to clients, and advocacy and care for the interests of persons unable to do so for themselves. The Code also stresses that counselors need to care for their own physical and mental well-being.**

Because the Code embodies so many values, counselors may find themselves in certain situations confronted by conflicts among values. These conflicts are at the root of moral dilemmas that demand thoughtful and considered responses. Although an ethical code in certain situations provides an unequivocal course of action for counselors faced with ethical problems, it is more often one of several important factors and alternatives to be weighed before a specific moral dilemma can be addressed.

Acting ethically demands certain proficiencies of counselors. Ethical counselors have the ability to recognize situations as moral; that is, as involving issues of "right and wrong." They integrate and balance various considerations into a course of action that they can justify rationally. They realize making ethical decisions involves complex perceptions and judgments. After deciding on a course of action, they implement their decisions with the awareness that one's actions not only reflect moral values, but ambition, self-interest, and a host of other less-than-altruistic motives.

Elements in Making Ethical Decisions: A Case Illustration

You have received a telephone request from a client's work supervisor for information about the client's emotional problems, especially a tendency to abuse alcohol when depressed. You have explained to the client the need to confront past emotional difficulties truthfully, and you have no reason to believe the supervisor has anything but the client's interests at heart. In fact, the supervisor has indicated a desire to create a favorable environment for the client's rehabilitation. **You have in the client's file a signed release of information form permitting you to share relevant information about the client with anyone involved in the client's rehabilitation. How will you respond to the supervisor's request?**

In this relatively simply illustration, what are the ethical issues to be considered? What values may be in conflict? What clients rights are relevant to the decision about sharing information? What federal, state, and/or municipal laws or regulations have some bearing on the issue of confidentiality and legal protections for people recovering from substance abuse? Does your agency have a policy about responding to requests for information over the telephone? Does a telephone request call for a different response than a written request? What are the relevant Rules in the Code of Professional Ethics for Rehabilitation Counselors? What clinical and rehabilitation issues have some bearing on your response? What benefit might come to the client? What harm? What other issues might bear directly or indirectly on your decision?

Having considered the general ethical and related issues, you might think of several possible responses to the client's supervisor. After comparing and assessing the feasibility of each in light of ethical principles and relevant information, you make a provisional decision. You then subject that decision to relatively rigorous testing by examining the decision's rationale, proposing counterexamples, and comparing it with some ethical theory or standard of professional conduct. You may consult other professionals for their analysis and insights.

Your initial decision may need to be revised or may have to be abandoned. You then consider another response, which you subject to the same process of testing. Once you are satisfied that you have adequately addressed the ethical demands of the situation, you can now implement the decision you've made.

Several ethical responses can be made to the request in the case illustration, each consistent with the circumstances and the sub-issues, each reasonably justified, and each in accord with the

important ethical values of the Code of Professional Ethics for Rehabilitation Counselors. With considerably more detail than provided, the case might admit of fewer ethical responses. What is important to note is that **even relatively simple situations raise complex issues and require more than superficial analysis.**

The Ethical Counselor

Ethical codes may incorporate and reflect important moral principles, but individual professionals act beneficently, nonmaleficently, justly, and with respect for a client's autonomy. Counselors' decisions on ethical matters are affected by a number of considerations. Their behavior originates from a well-developed ethical theory or strongly held religious beliefs. It may reflect various beliefs about social relationships and the extent to which governments and/or social agencies should intervene to alleviate problems or offset economic disadvantage. It may incorporate beliefs about human nature and "the way the world works." It may even be related to counselors' understandings of cause-and-effect relationships and of how persons can know what is true.

Like Hippocrates, ethical counselors understand ethical behavior comes from a life of personal integrity. Ethical counselors acknowledge their obligation to educate themselves about ethical matters. **Ethical practice in rehabilitation counseling does not depend on the Code of Professional Ethics for Rehabilitation Counselors; it depends on ethical rehabilitation counselors.**

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QUESTIONS BASED ON THIS LESSON

33. The Code of Professional Ethics for Rehabilitation Counselors revised in 1987:

A. Applies only to counselors in private practice

B. Has its origins in the Hippocratic oath but is shaped particularly for the specific practice of rehabilitation counseling

C. Is flawed by its failure to address such basic issues as refraining from exploiting clients and misrepresenting one's skills and experience

D. Specifically forbids the counselor from revealing a client's dangerous intent to prospective victims as is required of physicians under the Tarasoff vs. the Regents of the University of California decision

34. According to the Code of Professional Ethics, rehabilitation counselors are:

A. Precluded from being activists on behalf of the rights of disabled people

B. Forbidden to engage in sexual relationships with clients, but are not restricted from sexually exploiting coworkers or freely disparaging the competency of other professionals

C. Encouraged to accept rebates, commissions or other forms or remuneration for referring clients to professional services and agencies

D. Required to respect the confidentiality of information obtained from clients and to have permission in writing from clients or their legal guardians to give out any information about them to other involved parties

over, please...

35. Which of the following statements is/are correct:

A. All decisions facing rehabilitation counselors that have to do with ethical principles are simple and clear-cut

B. If the code of ethics conflicts with legally mandated ethical and professional standards, counselors should regard legal mandates as taking precedence, but should make ethics committees aware of such conflicts and attempt to effect change within agencies and organizations by constructive action

C. Since its adoption in 1987, enforcing the ethical code's provisions in response to complaints has been very easy

D. The Code sets stringent limits on the financial compensation of rehabilitation counselors in both institutional and private practice settings

36. According to Van Hoose and Kottler, basic client rights in the counseling relationship include all **except** which of the following:

A. Receipt of a signed statement from the counselor that he or she will respect the 1987 Code of Ethics

B. Informed consent

C. Confidentiality

D. Competent treatment

Directions in Rehabilitation Counseling

VOLUME 2 • LESSON 10

Techniques Designed to Energize Clients Toward Self-Help

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EDITOR'S NOTE

A primary responsibility of the rehabilitation counselor is to motivate clients to move closer and closer to self-reliance. To do so, it is necessary to develop a good counselor-client relationship. Once established, this can provide the setting for the application of a number of strategies to facilitate the goal of greater client independence. The author briefly highlights fifteen such approaches, including advising, assurance, depth interpretation, impersonal and personal illustration, informing, communicating incomplete thoughts for the client to complete, paradoxical intention, projection - interpersonal, future-time, and future-time reflection - suggestion, summary clarification, tentative analysis, and urging. Each of these tactics requires study and practice. Its application depends on the specific requirements of the individual client and the mastery of it by the counselor.

Introduction

In the process of assisting individuals with disabilities, professional rehabilitation counselors must perform numerous roles and functions.[1-4] Fittingly, their job tasks are quite extensive.[5] Nonetheless, **the *counseling* that they do with their clients**, whether it be affective counseling, vocational counseling, personal adjustment counseling, or a variety of other types, **is *sine qua non* to their overall effectiveness** and impact on the lives of the clients with whom they are working.

There are many definitions of rehabilitation counseling and what it entails. **I prefer to define rehabilitation counseling in rather simplistic terms: assisting individuals with disabilities in confronting the truths about their lives.** An essential consideration of this definition includes the proposition that **one of rehabilitation counselors' primary objectives is to energize their clients to do something to help themselves.**[6] Rehabilitation counselors do many things with, for, and on behalf of their clients. However, **facilitating self-help is they key to long-term rehabilitation.** I have always believed that rehabilitation is the process of helping people help themselves move from a state of dependency toward a state of independence. Thus, assisting people via a "facilitating self-help" approach to rehabilitation counseling is an excellent way to ultimately engender, encourage, and enhance meaningful independence.

Relationship-Building Attributes and Skills

It is critical for professional rehabilitation counselors to facilitate **building a meaningful relationship with each of their clients.**

important aspects of our counseling with our clients are: (1) they **feel comfortable with us**; (2) they **trust us**; and (3) they **genuinely consider us worth listening to** when we talk to them. Thus, it is paramount for rehabilitation counselors to be – and perceived by their clients to be – **warm and caring, honest, concrete, and authentic** (among other important attributes). Commensurately, during the relationship-building stage of counseling, rehabilitation counselors must demonstrate accurate **empathy and respect**. It is important to note that **when rehabilitation counselors demonstrate high-level relationship-building skills and attributes such as these, their clients feel good about *themselves*, their counselors, and their relationships with their counselors.** Moreover, at times they simultaneously feel energized toward self-help. Nonetheless, this is not always the case, so it is imperative for the professional rehabilitation counselor to have a variety of other "self-help energizing" counseling skills and techniques.[54]

Counseling Techniques Designed to Energize Self-Help

After the rehabilitation counselor has established a meaningful relationship with his or her client, he or she has an accurate understanding of the client's difficulties and surrounding issues, and there are mutually agreed-upon directions and goals, then it would be appropriate for the rehabilitation counselor to consider using more **active and directive counseling techniques designed to facilitate a self-help attitude and appropriate self-help activity** on behalf of the client. In my work with individuals with disabilities as a rehabilitation counselor and a licensed psychologist over the past 25 years, I have experienced the following 15 counseling techniques to be quite helpful. Each is described briefly and illustrated with a case study.

Advising

Advising is a directive counseling technique in which the counselor, using his or her experience, expertise and knowledge of the client, and all of the critical variables involved, tells the client what to do. The counselor must be sensitive, however, to the possibility that the client may not really want to do what the counselor is suggesting. Still, the client feels compelled to do what the counselor is advising anyway. If used appropriately, however, it can expeditiously engage a client in self-help behavior as well as in a desired direction.

Client Statement:

The client, a 26-year-old married white man with alcoholism, said, "I know I have only been on this new job for three weeks, but I just don't like it. I could probably stick it out for a while. But now that I'm there and I'm actually doing the work every day, I can tell that it's just not for me."

Counselor Response:

"I can see, Richard, that you're a bit frustrated and realize that the job's not for you. But **I'd advise you to stick it out for a while.** You need more time to get settled down into your new routine with your A.A. meetings and all – and used to your new life. Just hang in there for a while before making any more changes in your life."

Assurance

Assurance is designed to reduce the client's concerns and

worries about a particular decision, to increase his or her feelings of safety and confidence, and to minimize continued discussion regarding the decision. However, the counselor should be aware of the possibility that the client may transfer all responsibility for the decision and its subsequent outcomes to the counselor. If not abused (and thus becoming "reassurance"), however, this technique can be a powerful motivator and energizer.

Client Statement:

A single black woman, 31 years old, who suffered from mental illness said, "I realize that I just got out of the hospital a month ago. Sometimes I just get scared, though. I really hope that I can make it. I don't want to have to go back."

Counselor Response:

"I can see that you're a little nervous about being out here and not wanting to go back. But, Gloria, **I feel confident (with good reason) that everything will work out for you.** You'll see. It will all work out for you."

Depth Interpretation

The counselor, based on his or her accurate knowledge of the client and his or her theory of personality dynamics, offers an interpretation of the client's statements and/or behavior. Accurate awareness of the client's past and present experiences is critical, as is a high level of psychological expertise and skill. If the client is demonstrating resistance and experiencing intense feelings, for example, this technique can be very effective.

Client Statement:

The client, a 34-year-old Hispanic man, became a quadriplegic as a result of an accident. He said, "Now that I'm working, I can tell that my kids, my wife, and my parents are proud of me. But sometimes **I see that look in my father's eyes – it's like I wonder just how he *really* feels about me."**

Counselor Response:

"Juan, I know your father's feelings about you are important to you, especially since your accident. I also sense that after all these years of hearing, 'This is my son, and some day when I'm gone he'll be head of the family,' you are afraid that he has lost confidence in your being able to take care of your mother and younger sisters when he's gone. You feel that he wants you to carry on in the family tradition."

Illustration – Impersonal

Impersonal illustration provides an indirect way of offering alternatives, ideas, suggestions, and encouragements by sharing the experiences of a third person. The counselor should be sensitive to the client's feelings about the counselor's "talking about someone else." Nonetheless, if the client is receptive, it can also be comforting to know that others who have been in similar situations have successfully handled the issue(s) at hand.

Client Statement:

Alice, a 42-year-old woman, suffered a stroke. She told her counselor, "When my family all talk to me at once – you know, the kids, my husband, my mother and father – they get upset with me because I need more time to answer them. Then they just walk away and I never get a chance to say what I want to say. Know what I mean?"

Counselor Response:

"A woman I was working with about a year ago had a similar problem with her family. You know what she did, Alice? First she discussed it just with her husband. Then one Sunday after a family dinner, **they called a family meeting, everyone sat in the living room and her husband told them all to just listen to her.** She then told all of them what was happening and what she was feeling."

Illustration – Personal

Somewhat similar to impersonal illustration, the personal illustration technique is characterized by the counselor's indirectly offering alternatives, ideas, suggestions, and encouragements by **sharing his or her own experiences.** The counselor should be sure to assess how the client feels about the counselor's talking about himself or herself, as well as the extent to which the client may feel obligated to do what the counselor is saying. Nonetheless, when used properly, this "personally relevant self-disclosure" technique can be very helpful.

Client Statement:

A 27-year-old divorced white man who was epileptic said, "Every time the guys at work ask me what's wrong with me (see, they know that I got help from vocational rehabilitation), I change the subject or walk away. Now they think I'm crazy. I just can't seem to get the words out. **I'm afraid that if I try to explain epilepsy to them, I'll screw it up. I don't know what to do."**

Counselor Response:

"Sometimes I have similar situations myself – you know, where you want to explain something to people and you just can't get the words to come out. **But let me tell you what works for me. I sit down and write out what I want to say. Then I get with a friend and practice saying it. Then when I get with strangers, I am able to say what I want to say.** Maybe I then have confidence in myself. At any rate, all I can tell you is that it works for me."

Informing

When the client is unaware of – or is not knowledgeable about – something critical to his or her rehabilitation, the informing technique offers an effective manner of conveying pertinent information. **Reading a booklet, a pamphlet, or other forms of information provides the client an opportunity to do something for himself or herself, and it ultimately helps the client in asking grounded questions and in making informed (better) decisions.**

Client Statement:

A 38-year-old single black man underwent an above-the-knee amputation. After surgery, he told his counselor, "The doctor told me about this new Reflex-Knee artificial leg, but I really don't know anything about it. He wants to fit me for one. But, I just don't know."

Counselor Response:

"Al, I have a booklet here in my desk. Yeah, here it is. See this, this is a brochure that tells you all about all kinds of artificial limbs...and look, here's a bunch of stuff on the Reflex Knee. I'd suggest that you take this with you and read up on it. There's also a toll free number you can call if you have any questions about it."

Incomplete Thought

In the incomplete thought technique, the counselor deliberately pauses in the middle of a sentence and subtly invites the client to complete it. When the counselor determines it is important for the client to talk about a particular topic, this technique helps draw the client into doing so.

Client Statement:

Marlene, a 41-year-old married woman who had undergone a colostomy, told her counselor, "Now that the summer is here, all of the people at work are going to have the monthly get-together at John's house – he has a pool. If I don't show, they'll be upset with me. So, I'll go. But, everyone will be wearing bathing suits and fooling around in the pool."

Counselor Response:

"And it sounds to me, Marlene, that you are afraid that when everyone else is in their swimming suits and you're standing there without your suit on, they will say..."

Paradoxical Intention

In paradoxical intention, the counselor offers a ridiculous or an incredibly overstated eventuality pertinent to the issue being discussed. The counselor should feel assured that a good relationship has been established and that the client understands the point that the counselor is making (and does not take him or her literally). **If the client smiles, says, "O.K., I hear you," or maybe even laughs a little, this may be an indication that the client heard the paradox.** This technique can be very helpful in facilitating a client's self-insight.

Client Statement:

After the amputation of her right hand, Maria, a 23-year-old divorced Hispanic woman, said, "Carlos doesn't know about my hand. See, every time he comes into the office, **I sit behind my desk with my hand, well my artificial hand, on my lap.** And this Saturday night I'm going out to dinner with him. And you know what's going to happen. **He's going to find out."**

Counselor Response:

"Of course, Maria. **And then you know what he's going to do – he's going to have the orchestra stop playing, the drummer will give a drum roll, the spotlight will be directed on you, and he will say, 'Ladies and gentlemen, here with us tonight we have...'"**

Projection -- Interpersonal

Interpersonal projection is designed to assist the client in understanding another person's viewpoint by looking at an issue or a situation *through their eyes*." In effect, the counselor is asking the client to play the role of the third person (psychologically). With an enhanced understanding of the third person's perspectives, the client's own understanding, appreciation, and insight of himself or herself and the "bigger picture" is enriched.

Client Statement:

A blind 36-year-old single black man asserted, "Every time I ask someone at work if they would like to go out for lunch instead of eating in the cafeteria – especially if it's a female – they say 'Not today, I'm not that hungry,' or, 'I'm afraid that it may rain.' **What are they afraid of? Blindness is not a contagious disease."**

Counselor Response:

"No, of course not, Walt. But let's try something, Walt. **Think back to when you had your sight.** Only try to envision yourself where you work now. You go to work every day, you never have met nor spoken at length to a blind person. And all of a sudden, there's a guy working in your area who is blind. He can't see anything. You wonder how he manages to do anything. And then he asks you if you want to go out to a restaurant for lunch. **How would you feel if that were to happen to you like that?"**

Future-Time Projection

Through future-time projection, the counselor assists the client in **projecting himself or herself into the future, ultimately to obtain a better understanding of the present.** It is important, however, **for the counselor to accurately assess the client's cognitive capacity to engage in futuristic thinking.** This technique also facilitates opportunities to discuss present options and related requirements pertinent to future issues, projected outcomes, and desires.

Client Statement:

Betty, a 30-year-old divorced white paraplegic, said, "I like the work, and the people are friendly and fun. I guess that **I just can't see myself doing that job -- or that kind of work, for that matter -- for the rest of my life."**

Counselor Response:

"I hear you. It sounds like you're a little bored and the work is not challenging or exciting any more. But let me ask you to think about something and respond to a question. **Suppose you and I were to meet in an airport five years from now** and I said to you, 'Betty, you and I haven't seen each other for five years. **What are you doing now?' What would you like to be able to tell me in your answer to my question?"**

Future-Time Projection with Reflection

With this technique, **the counselor is inviting the client to project himself or herself into the future and then "look back to the**

present." As with Future-Time Projection, **the client's cognitive capability must be accurately assessed.** This futuristic, retrospective path analysis experience on behalf of the client can indeed be **very helpful in appreciating how current issues and decisions may affect the future.**

Client Statement:

A 46-year-old husband and father who lost his left foot told his counselor, "I've got to stay on this job, at least for the next two years until the kids finish college. But then I don't know what I'll do...you know, with this foot gone and all. But I know I won't be doing what I'm doing now."

Counselor Response:

"Well, let me ask you this. Suppose you and I were to meet in a mall five years from now. And after we sat down to talk, I said to you, 'Chuck, **look back over the past five years since we last saw each other and tell me – what have you been doing?' How would you like to be able to answer that question five years from now?"**

Suggestion

Suggestion is a nondirective technique designed to offer alternatives or other possibilities while savoring the client's self-direction and responsibility for his or her own decision making. When used properly, the client genuinely feels comfortable in either accepting or rejecting the suggestions being offered by the counselor.

Client Statement:

A 24-year-old single white male with a hearing impairment, Jerry commented, "Things are going fine at work; the boss likes me and I'm doing very well. But I just want to get away from all the people I met in that group – they're all hearing impaired. What do I have to do to meet 'normal' people?"

Counselor Response:

"I can offer two suggestions to you to consider or think about, Jerry. First, I'd suggest getting a copy of Creative Loafing, a singles magazine published here in the area. Secondly, I'd suggest contacting 'Bay Winds,' a group that organizes get-togethers for singles – you know, like picnics, dinners, outings, and the like. Its purpose is to help people meet people."

Summary Clarification

With summary clarification, the counselor organizes and summarizes what has been discussed. The counselor also should express his or her summary clarification in a manner that will allow the client to feel free to comment on, clarify, or even disagree with the counselor's statement. Frequently, this also is perceived by the client as a signal from the counselor that the conversation on the particular topic is concluded and it is time to move on to something else.

Client Statement:

After her heart attack, a 52-year-old married Hispanic woman said, "Well, O.K., I guess I'll just keep plugging along with my program and see how things go."

Counselor Response:

"All right. But, Kasy, **let's just take a moment to see where we are.** We discussed your new position at the company that seems to be going well for you. You're following your diet and walking two miles every evening. And you plan to talk with your husband and your two sons about your needing a little help with the housework. Does that just about get it?"

Tentative Analysis

Through tentative analysis, the counselor offers his or her **diagnosis of the problem, difficulty, or issue being discussed.** The counselor provides the client with the bottom-line conclusion(s) of his or her study of the issues and possible causes and contributing factors involved. With this technique, however, it is important that the counselor **underscore the tentative nature of his or her diagnosis, thus leaving the client free to accept, reject, or comment on the diagnostic understandings that the counselor has offered.**

Client Statement:

Laura, a 28-year-old white divorcee, underwent an above-the-knee amputation. She told her counselor, "My girlfriends keep asking me to go out with them – you know, a simple dinner, maybe a few drinks or a movie. But I don't know, I need to lose weight, fix up my hair, my nails are cruddy...I don't know...I'm just not motivated to do any of those things right now."

Counselor Response:

"Well, as I'm sure you are aware, Laura, there are many possible explanations for all of this. But **I wonder if maybe you are subconsciously thinking,** 'Hey, but if I lose weight, and get my hair and nails fixed, then I'd kind of have to go out with the girls and then possibly someone might talk with me and even ask me to dance – then I'd have to face a lot of reality with regard to my leg.'"

Urging

Urging, similar to "advising," is a directive technique by which the counselor is trying to encourage the client to follow a certain course of action. This is a power-related technique; in effect, **the counselor is using the power of the counselor-client relationship to motivate the client in a particular direction.** Thus, it is important for the counselor to **accurately assess the direction being reinforced** and the possible consequences of the counselor's urging on the client.

Client Statement:

A single black mentally retarded 19-year-old man asserted, "I know I could do that work in the new office building. I'm one of the best workers they have. **I was thinking that maybe I would talk to my boss and ask him to try me out over there.** I don't know what he would say."

Counselor Response:

"Steve, **that's a great idea.** I think that tomorrow when you get to work, you should talk with your boss and tell him just what you just said to me."

Summary and Conclusions

Rehabilitation, the process of helping people help themselves move from a state of dependency toward a state of independence, is critically dependent upon the work of the rehabilitation counselor. When rehabilitation counselors can energize their clients toward helping themselves, their clients invest in their own rehabilitation and have an enhanced opportunity to experience independence.[6,9] **In their counseling roles and functions, rehabilitation counselors must (a) build and maintain meaningful relationships with their clients and (b) energize their clients toward self-help activity.** The 15 active and directive counseling techniques briefly described and illustrated in this lesson, when used appropriately and with high-level clinical skill, can be very helpful in energizing clients toward self-help activity.

Along with the study and practice of these counseling techniques, rehabilitation counselors are encouraged to explore the pertinent philosophical assumptions and theoretical tenets underlying them.[6,7,10] Rehabilitation counselors are urged to consider that: **(a) some of these techniques tend to be differentially appropriate (e.g., in certain situations, with certain individual clients, and on behalf of the individual attending counselor);** (b) **some are more or less effective with clients who have differential disabling conditions;** and (c) **some are advanced techniques which need to be used judiciously.** Nonetheless, with careful clinical skill, the 15 selected active and directive counseling techniques can be very helpful in the process of assisting individuals with disabilities in engaging in self-help activity, moving toward a state of independence, and ultimately experiencing successful and meaningful rehabilitation.

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QUESTIONS

37. When the rehabilitation counselor shares an experience of his or her own to give a client a new way to view or handle a difficult situation, this strategy is called:

A. Depth interpretation

B. Assurance

C. Illustration – personal

D. Incomplete thought

38. Which of the following statements is correct?

A. In promoting self-reliance, counselors should *never* offer depth interpretations to clients, no matter how well they understand the client's history and psychodynamics

B. Assurance should always be grounded in a realistic appraisal of the client's condition and prospects and never given without basis

C. If one correctly applies the 15 techniques described to facilitate client self-help, a good client-counselor relationship is unimportant

D. The technique called "incomplete thought" requires that the counselor never communicate with the client in full sentences.

over, please...

39. When *advising* a client, the counselor should:

A. Base all such instruction upon the counselor's own personal experience without taking his or her knowledge of and experience with the client into account

B. It's never appropriate to describe a third person's experience to enable a client to gain new understanding even if the identity of the third person is not revealed

C. In using paradoxical intention, wherein the counselor offers a ridiculous or overstated eventuality pertinent to the issue being discussed with a client, be sure the counselor-client relationship is solid and that the client truly grasps the point being made

D. To force clients to think and act for themselves, never offer an organization and summary of what has been discussed

40. What is the strategy in which the counselor asks the client what he or she would like to say he's doing if they run into each other five years hence?

A. Future-Time Projection

B. Projection – Interpersonal

C. Paradoxical Intention

D. Urging

Directions in
Rehabilitation
Counseling

VOLUME 2 • LESSON 11

The Effective Use of Vocational Evaluation Services

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Directions in Rehabilitation Counseling
VOLUME 2

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EDITOR'S NOTE

In this lesson, the author distinguishes between routine vocational assessments conducted on all clients by rehabilitation counselors and a more complete vocational evaluation to be done more selectively, primarily in clients whose occupational direction is in question. A vocational evaluation systematically uses real or simulated work as the focal point for assessment. Short-term evaluations, sometimes only diagnostic in nature, may be useful for persons with already established skills and abilities and who are not severely disabled. Long-term vocational evaluation is more appropriate for clients with severe disabilities who have no vocational direction and difficulty learning. Whether a particular client is ready for evaluation depends on his or her overall condition. A client's willingness can be fostered by intelligent, careful preparation and orientation by the rehabilitation counselor.

In making a referral, the counselor will receive more valuable feedback if he or she provides specific written referral questions to be answered. Other pertinent medical and psychological information should also be provided to the vocational evaluator, being sure proper release of information forms have been signed.

The author defines what the counselor can expect from the evaluation and strongly encourages two-way communication between counselor and evaluator throughout the process.

Introduction

The effectiveness of vocational evaluation services has been well documented.[1-3] **Studies that compared success rates obtained when report recommendations were followed versus not followed suggest that vocational evaluation can make a significant difference in placement success when properly used in the rehabilitation planning process. Inadequate planning and placement outcomes can result, in part, from an improper evaluation and report or from a lack of counselor understanding of how to correctly choose and use evaluation services and reports.** To help the counselor learn how to correctly employ vocational evaluation services, this lesson will describe the primary considerations for **systematically: choosing appropriate vocational evaluation services; determining client readiness for referral; writing objective referral questions; and using evaluation reports in effective rehabilitation client planning.** These procedures serve as important ingredients in improving the delivery of rehabilitation services.

A Working Definition

Not every client needs a complete vocational evaluation. As surprising as those words may sound, for the most part **vocational evaluations should be provided only when a client's occupational direction is in question. Routine vocational assessments conducted on all clients by rehabilitation counselors may be all that is needed to develop a rehabilitation plan.** However, if the assessment reveals a need for additional information, the counselor can choose the evaluation service, e.g., medical, psychological, educational, or vocational, that can best answer the question. To fully understand the difference between **vocational evaluation** and **vocational assessment**, the widely accepted definition by the Vocational Evaluation and Work Adjustment Association (VEWAA) will be used. Both the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES) have adopted the following **VEWAA definition of vocational evaluation:**

> **A comprehensive process that systematically uses work, either real or simulated, as the focal point for assessment** and **vocational exploration, the purpose of which is to assist individuals in vocational development.** Vocational evaluation incorporates medical, psychological, social, vocational, educational, cultural, and economic data into the process to attain the goals of evaluation.[4]

Unique features of this definition that distinguish vocational evaluation from other evaluation services is **its focus on "real and simulated" work, and its broad inclusion of a variety of considerations that influence work,** such as medical, psychological, social, educational, cultural, and economic factors. It is important to keep in mind that **vocational evaluation is much more than testing.** If all clients and jobs were alike, then highly valid computerized test batteries would be in common use today. The fact is that **the more subjective factors -- motivation, interest, behavior, maturity, communication, and support -- account for much of the variance in vocational decision making. Those factors cannot be easily measured by a computerized test battery and require "real or simulated" work environments to provide an accurate clinical assessment.** Even the term measure is suspect, given the variability of people and jobs, and especially people with disabilities who now have greater access to job modification and accommodation under the law. This makes the use of clinical judgment within an ecological evaluation even more important today.

Assessment, on the other hand, is a less formal technique that is routinely provided throughout the life of a rehabilitation case.[5] It begins when the application for services is reviewed and the client is met and ends with the close of the case. It is a multidisciplinary process that involves the coordination, collection, and analysis of formal evaluation data to assist in making planning decisions. It could involve observing client behaviors and characteristics during the initial meeting as well as reading and synthesizing a vocational evaluation report. The accuracy of a good vocational assessment depends in part on the quality of a good vocational evaluation. Vocational evaluation is part of the vocational assessment process and may not always be needed, depending on the utility of other assessment information.

Choosing a Vocational Evaluation Service

The rehabilitation counselor should take the time to carefully "evaluate" vocational evaluation services. Who would buy a car without first taking it for a test drive? Such caution should also apply when purchasing vocational evaluation services. Several important guidelines should be followed when determining the appropriateness of an evaluation service for a specific client. Not all vocational evaluation services work for every client. A short-term vocational evaluation (or vocational screening), ranging in length from several hours to several days, may yield pertinent information for individuals who are not severely disabled, or for persons who may already have well-

established skills and abilities and simply need guidance to properly apply those skills in the right job or training program. On the other hand, persons with severe disabilities who have no vocational direction and have difficulty learning and generalizing information, may need a long-term vocational evaluation that may last from several weeks to several months and rely on simulated and real work settings to modify and evaluate performance, behavior, and environmental considerations.

Many of the short-term services only have enough time to provide a diagnostic vocational evaluation – where the client is at the current time. **Do not expect such services to provide detailed information on specific behavioral issues, stamina, performance improvement and maintenance, career exploration, and particular environmental accommodation and modification options.** For example, how can a person's stamina to work an eight-hour-a-day, five-day-a-week job be assessed in only a few hours? How can communication and cooperation skills with coworkers and supervisors be evaluated from an intake interview or with a standardized test? Although such evaluations are often attempted, they are of questionable value.

Services of a longer duration can frequently offer a prognostic vocational evaluation – *where the client could be* with specific services and accommodations. Time is needed in this latter evaluation process to assess behavior, accommodation needs and strategies, learning contingencies, performance improvement, and environmental considerations.

Evaluators in short-term evaluation settings often recommend a client be referred to long-term evaluation to further assess critical factors that could not be adequately addressed. The practice is no different from referrals made by family physicians to medical specialists when there is need for a more precise diagnosis and formulation of a specific plan of action. Short-term vocational evaluations provide an important service to a wide range of client populations, but, with more severe disabilities, they may not furnish all the essential information required for accurate planning. At times, they may only serve to screen out some clients who, with a more appropriate long-term evaluation, could receive better direction and opportunity for success.

Questions that should be addressed when determining the appropriateness of a vocational evaluation service include, but are not limited to:

1. **How severely disabled is the client, and what are the information needs?**
2. **What is the length of the evaluation service and what instruments and techniques are used?**
3. **What can be expected from the vocational evaluation in terms of report content and outcomes?**
4. **Is the evaluator competent to provide the desired service?**

Preparing for Referral

Referral preparation, an often-overlooked phase, can make a difference in the success of a vocational evaluation. It requires that the rehabilitation counselor **first determine if the client is currently appropriate for vocational evaluation services. Two areas of appropriateness must be determined: client readiness and client**

willingness.[6] Client readiness refers to the stability of the condition. If full medical and mental recovery is not achieved prior to referral, then the evaluation may only serve as a diagnostic, motivational, therapeutic, or career-exploration tool. **The presence of stability is often a difficult decision to make, because stability of the condition requires subjective judgment, e.g., when a person with traumatic brain injury or chronic depression would be ready for vocational evaluation. Vocational potential may be underestimated in such cases. On the other hand, delaying evaluation will lengthen rehabilitation cost and time and may diminish overall rehabilitation success.[7] When in doubt about the appropriate time of referral, consult the vocational evaluator.** Communication between the counselor and evaluator is essential for ensuring appropriate referrals.

Determining client willingness is an equally complex process in establishing a client's readiness. **It refers to the client's personal and emotional readiness to participate in a vocational evaluation.** Persons who are experiencing difficulty adjusting to their disability or are undergoing a personal crisis such as divorce, financial difficulties, court trial, or struggling to overcome substance abuse, may not be willing to explore vocational options until the problem is resolved. Again, vocational evaluation may serve to refocus a client's attention to more positive life directions, but could result in an underestimation of vocational potential if the client is not fully committed to the process.

The level of client willingness can be ascertained and often improved through counseling and orientation. Counseling can be used to explore the client's commitment to entering and actively participating in evaluation. However, that requires **orienting the client to**

what will happen in evaluation, what will result from the process, and how the results will be used in vocational preparation and placement. Some persons enter vocational evaluation with apprehension as a result of a lack of understanding or a misconception of what will happen. Some may think they will be "tested" or "trained" and will be fearful, anxious, or even suspicious of the process. **The orientation should positively focus on clients' unique opportunities to explore their own personal interests and abilities as they relate to options for vocational training and job placement. Words such as "testing" should be avoided since they have a negative connotation.** Emphasizing the client/evaluator partnership role will give the client a sense of ownership of the process, and may increase willingness to participate. Counselors may also wish to offer apprehensive clients a tour of the evaluation unit or supplement the orientation with printed materials and brochures on vocational evaluation in general and on the unit in particular.

Writing Referral Questions

One of the most important ways a counselor can communicate information needs to the vocational evaluator is through the referral question. **The most typical referral directive asks the evaluator to find out everything possible about the client. However, more specific referral questions will ensure that primary information needs will receive special attention in evaluation.** At times, counselors who are less than satisfied with evaluation results may find they did not take the time to ask a few simple referral questions. Counselors should feel free to request a comprehensive evaluation while asking for more detail in a few key areas. **Specific questions may relate to identifying client interests and work values, work stamina, behavior, communication and cooperation, remedial needs, ability to return to a previous job, best instructional approaches, type of training best suited to the client, or transitional needs. Caution should be used in writing referral questions that cannot be answered by an evaluation unit because of program length of staff expertise and qualifications.** In other words, do not ask for an assessment of work stamina from an evaluation of several hours or request a personality or mental status diagnosis from a unit not staffed by a licensed psychologist. When in doubt about the appropriateness of a referral or referral question, do not hesitate to consult the evaluator in charge of admissions. Prompt communication will save valuable time and money frequently lost through an unnecessary referral.

Whenever possible, include copies of special medical, psychological, or other pertinent evaluation reports or summaries, making sure that a consent for release of information form has been signed by the client. They may be crucial to writing recommendations that take into account all possible factors directly or indirectly related to the overall vocational potential of the client. In addition, **evaluators place clients in a variety of physically and cognitively challenging and potentially stressful activities; knowing what situations to avoid will minimize the chance of harming the client.**

What to Expect from the Vocational Evaluation Process

Once a **referral** has been processed and accepted, the counselor and client will be notified of the start date. Immediately prior to the evaluation, the counselor must **ensure the client will be attending, knows where to go and when to be there, and has dependable transportation to the unit.** This minimizes "no-shows" that may place the client at the end of the waiting list. Again, **any fears or apprehensions of the client about participating in evaluation should be discussed and resolved.**

Although vocational evaluation approaches differ, a general outline of the process, from the client's perspective, will be presented to give some idea of what can be expected in terms of typical assessment strategies. Understanding the process will provide a better appreciation of – and the reasoning behind – the content of evaluation reports.

It is important to locate experienced and qualified evaluators that have the extensive knowledge and skills to offer a comprehensive, creative, and clinically oriented service. They should be able to modify instruments/techniques and accommodate and facilitate client performance. Facilities that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) in vocational evaluation typically use qualified evaluators. Personnel that have been formally educated or extensively trained in vocational evaluation, or who are Certified in Vocational Evaluation (CVE) by the Commission on Accreditation of Work Adjustment and Vocational Evaluation Specialists (CCWAVES), should be able to provide the quality service desired.

File Review:

Review of the client file inaugurates the evaluation process. Pertinent information garnered from the file is used to initially develop the **individualized vocational evaluation plan** (IVEP). The IVEP contains the referral questions as well as additional questions derived from the file review. The primary factors associated with each question, and the instruments and techniques needed to evaluate these factors, are the major content areas of the IVEP.

Information Questionnaire and Intake Interview:

Frequently, upon admission, evaluees must complete an information questionnaire. This simulated job application form permits the evaluator to assess writing style, comprehension and written expression, ability to complete a job application form, and information on past and future aspirations. The questionnaire is used during the initial orientation and intake interview to help explain how the evaluation will specifically benefit the stated needs and aspirations of the client and to provide guidance in exploring critical information areas in greater detail. The intake interview will also facilitate assessment of: job interviewing skills; general communication skills; initial behaviors and appearance; and responses to questions related to perceived strengths and needs, vocational history and goals, education, personal/social/family issues and supports, finances, disability and medications, hobbies and interests, and transition skills and needs. The interview may also be supplemented with a functional assessment of the evaluee's physical capacity and basic living skills.

Plan Revision:

The intake interview is often followed by a revision in the vocational evaluation plan in order to individually tailor the remaining process to the client's expressed needs. Plan revision is an on-going

process that changes as necessary. Depending on the severity of the disability and information needs, the evaluation may take several different directions.

Feasibility and Employability Phases:

For individuals with severe disabilities, a prevocational evaluation will be administered to assess current training or employment feasibility. It may include an assessment of interest and work values, basic skills, functional skills, achievement, aptitude, dexterity, and learning style. **Results of the prevocational evaluation will determine if additional evaluation of employability skills is necessary** and/or what additional services would be required prior to placement, training, or further evaluation. Persons who are not severely disabled may be given an assessment of interests and work values, achievement, aptitude, and dexterity.

Standardized tests are frequently used as a quick and reliable method to collect objective information on clients. However, because of poor reading levels, text anxiety, disability, accommodation needs, processing time, lack of realism and concreteness, and inappropriateness of many tests for use in rehabilitation settings, standardized tests do not always provide an accurate appraisal of a person's true ability. **They tend to be limited primarily to vocational diagnosis** (baseline establishment), and may instead screen clients out of further evaluation – and possibly out of the rehabilitation process as well. Therefore, **the use of simulated and real-work instruments and techniques must be considered a more accurate evaluation of vocational potential and direction.**

The employability phase incorporates many of the same instruments and techniques found in the **feasibility phase**, such as standardized tests and behavior observation, along with work samples, situational assessments, and job-site evaluation. **Work samples are simulations of work tasks that possess psychometric properties of standardization.**[8] The clinical **advantages of work samples** over standardized tests include opportunities for **interaction with the client, career exploration, modification and accommodation, evaluation of production improvement, observation of critical vocational behaviors, identification of work-related needs, and an analysis of criterion-referenced (content-specific) as well as norm-referenced performance.**[9] Because of this flexibility, work sample evaluations take more time but provide a realistic assessment of work-related needs and capabilities. They are **one of the better methods to evaluate the abilities of persons with severe disabilities who do not perform well on standardized tests.**[10] Contingencies for improving performance and ensuring success can be prescribed through the creative use of work samples and work sample systems.

Situational assessment is a frequently used technique for evaluating work-related behavior. **This systematic but nonstandardized technique enables the evaluator to create work situations not always represented by work samples and often more characteristic of locally available jobs. For example, to assess a client's ability to perform and attend to tasks related to service occupations, an evaluator could direct the client to vacuum the floor and/or clean the windows in the unit.** This would create an environment in which the client's behavior, memory, attention to task, decision-making skills, and general quality of work can be observed and reported. Modifications to enhance work speed, quality, or retention and recall can be applied to evaluate their overall impact on performance. Successful accommodations and adaptations can be discussed in the report as they relate to comparable changes in successful training or work.

Job-site evaluation is the most valid and realistic technique for determining work potential. Because of the difficulty in developing and monitoring such sites, and the Department of Labor regulations requiring remuneration for any work that benefits employers, job-site evaluation is not frequently used. Placement and assessment in appropriate job sites is guided by previous evaluation findings, and may last from several days to several weeks. Situational assessments and job-site evaluations are more commonly used in long-term vocational evaluations and are **primarily designed for use with persons who have severe disabilities.**

Communication and Validation

Vocational evaluation is often concluded with an **exit interview. Clients are given an opportunity to express their opinions concerning the evaluation process as well as personal feelings about the types of work or training they might be willing to consider at this point in time. The evaluator synthesizes all of the information collected and formulates recommendations to be shared in the final staffing (optional) and written report.** The staffing often helps to refine results and reach **a group consensus** on client directions and alternatives that will be presented in the final report.

On average, **vocational evaluation reports are sent to the**

referring counselor approximately two weeks from the date of client termination. The typical report contains four distinct sections: identifying information, the body of the report, summary and recommendations, and report attachments (optional appendices). "The identifying information establishes the client identity; the body of the report explains what happened during the evaluation and interprets, documents, and justifies the results; the summary abstracts what was written in the body of the report, and the recommendations identify plans of action; and the report attachments provide additional information on test/work sample descriptions and outcomes."[11] Depending on the length of the vocational evaluation, **reports may vary in length from two to six pages, not including appendices.**

Prescriptive Recommendations:

Special attention is paid to writing **prescriptive recommendations, which spell out educational and vocational contingencies that must be addressed in the rehabilitation and placement process to improve chances for success.** Examples of recommendations include, but are not limited to, the following types.

Placement. Placement in jobs or training may be **direct** (no services needed), **selective** (selecting environments that fit the client), and **descriptive** (providing interventions, adaptations, or supported employment).

Education and training. On-the-job training or apprenticeship; remedial, vocational, or formal education.

Behavioral and emotional adjustment and counseling. Personal therapy, social counseling, family therapy, work and career guidance.

Independent living. Transportation, housing, consumer skills, finances, recreation/leisure, community resource access, basic skills, grooming/dress, and medical needs and services.

Assistive technology. Whatever is required at work or home or to provide transportation and security.

Referral for additional evaluations. Medical, educational, psychological, or assistive technology needs.

When recommendations require further explanation prior to use in planning, contact the evaluator for a consultation. Although report recommendations are the primary source for plan development information, the body of the report can provide detail regarding activities the client can perform, such as content descriptions of tests and work samples successfully completed. It also contains **thorough descriptions of behavior, useful adaptations and modifications, and vocational assets and limitations.** When these factors are incorporated into the **Individualized Written Rehabilitation Program** and thoughtfully considered in the rehabilitation and placement process, the probability of success will be increased. If the content of the report does not meet assessment and planning needs, the rehabilitation counselor must work with the evaluator to modify the report to improve written communication of available evaluation information. **Counselors must take the time to communicate to evaluators exactly what they want in written reports if they expect to receive helpful information.** As a rule, vocational evaluators are flexible and try to meet the needs of the rehabilitation counselor, as long as they know what it is the counselor wants.

Follow-up:

Follow-up is an important concluding step in any quality evaluation process. Follow-up forms are either included with the report or sent to the counselor some time after the report has been mailed. Because these brief forms are used to improve evaluation services, **it is in the counselor's best interest to objectively complete and return the form as soon as possible.** Without this feedback, evaluators will not have the information necessary to make the required changes. However, **if a counselor feels the evaluation or resulting report did not provide appropriate information to assist the planning process, then he or she should discuss this personally with the evaluator;** future evaluations can then be tailored to meet the counselor's specific assessment and planning needs.

Conclusion

Vocational evaluation is a dynamic process that changes to meet the changing needs of each client. When evaluation services are carefully chosen, the counselor will have a better chance of receiving information that will competently serve the planning process and assure client success. **Two-way communication between the counselor and evaluator is the cornerstone of a quality evaluation.** Providing the evaluator with thorough client information and appropriate referral questions will ensure the receipt of a highly useful vocational evaluation report. When evaluations become a part of the counselor's service delivery process, opportunities to optimize client placement are increased. Together, the goal of improving the quality of life for persons with disabilities can be realized and client empowerment in the rehabilitation process achieved.

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QUESTIONS

41. A complete vocational evaluation:

A. Should be done by rehabilitation counselors for every client

B. Uses only simulated work as the focal point for evaluation

C. Is always short-term, and only provides diagnostic information

D. Must often be long-term in nature with clients with severe disabilities, no vocational direction, and difficulty learning

42. Client readiness, a factor determining the appropriateness and timing of a vocational evaluation referral, means that:

A. The client is willing to go for evaluation

B. The client's condition seems sufficiently stabilized to permit an effective evaluation

C. Nothing more can be done for the client from a medical or psychological vantage point

D. The client has the funds necessary for the evaluation

over, please...

43. In making a referral for vocational evaluation, the rehabilitation counselor should:

A. Avoid providing specific referral questions lest he or she bias the evaluation

B. Try not to ask referral questions which cannot be answered as a result of a program's length or lack of staff expertise

C. Never include copies of medical or psychological data about the client

D. Not try to orient or motivate the client to participate

44. The most valid and realistic technique to evaluate work potential is:

A. Job site evaluation

B. Situational assessment, a nonstandardized method permitting the evaluator to create work situations not always represented by work samples and often characteristic of locally available jobs

C. Work samples, simulations of work tasks that possess psychometric properties of standardization

D. Standardized tests to assess clients' vocational preferences

Directions in Rehabilitation Counseling

VOLUME 2 • LESSON 12

Supported Employment: An Overview for Rehabilitation Counselors

James Schaller, Edna Mora Szymanski, PhD, and Cheryl Hanley-Maxwell, PhD

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EDITOR'S NOTE

Supported employment is defined as competitive work in an integrated setting for individuals with severe handicaps who have never been competitively employed, whose employment has been interrupted or intermittent as a result of disability, and who need ongoing support services to perform such work. A careful history of a client's work background; his or her skills and occupational abilities, interests and aspirations; suitability or unsuitability for various kinds of jobs; the kind of supports the individual will require to learn job tasks and related social skills; as well as contributory support such as special transportation and recreational opportunities – all these are part of assessing the client for supported employment. The objective is to attain person-job congruence, and when discrepancies are identified, determine whether and how to resolve or reduce these by various interventions. In this lesson, the author describes the input-process-output model of supported employment, which, when professionally and efficiently implemented, should produce a reasonable level of success as measured by client and client's family satisfaction with job placement and supportive services, satisfaction on the part of the employer with the job done and agency support services, job stability for the client, and benefit to the community from workers with severe disabilities being integrated throughout the work force producing valued goods and services.

Introduction

Supported employment has become a service delivery option and an employment alternative for people with severe disabilities,[1] thereby adding new options for rehabilitation counselors who serve persons with severe disabilities. Although supported employment was initially demonstrated to be a successful option for persons with mental retardation, it has been found to be beneficial for persons with a wide range of disabilities, including chronic mental illness, dual sensory impairment, and traumatic brain injury.[2] The purpose of this lesson is to introduce rehabilitation counselors to the supported employment option.

Background

Supported employment developed in the late 1970s and early 1980s as a response to a variety of factors, including the normalization movement and trends in special education. A review of these factors can help rehabilitation counselors understand some of the fundamental differences between supported employment and earlier service delivery approaches such as sheltered workshops.[2]

The primary tenet of normalization is the delivery of services in environs and with contingencies that are as culturally normal as possible.[3] Services that focus on participation and community integration are deemed culturally normal; services that segregate, including employment in a sheltered workshop, are considered abnormal.

As the normalization movement gained momentum, instructional strategies reflected increased emphasis on community-based services

and community functioning. In particular, training approaches allowed for more direct entry into the job market.[2] **The application of behavioral analytic procedures** (i.e., applied behavioral analysis) **was demonstrated to be highly effective in promoting acquisition, as well as generalization and maintenance, of behaviors and skills.**[4]

Instruction employing behavior analytic principles eventually became known as **systematic instruction**. Although it was initially used in educational settings, systematic instruction affected vocational rehabilitation. **The improved performance of people with severe disabilities that resulted from application of systematic instruction changed the perceptions of competence for the severely disabled by demonstrating that people could engage in behaviors previously thought to be beyond their ability.**[5]

Marc Gold and his colleagues merged systematic instruction and vocational practices, demonstrating that workers with severe disabilities could develop complex assembly skills.[6] Other researchers applied similar instructional practices in emerging supported employment programs around the country.[3]

The entry of systematic instruction into rehabilitation was accompanied by a shift in approach from training in a sheltered workshop in preparation for possible placement to **placing people in community jobs and then providing training and support services on the job.** The latter approach was adopted after research demonstrated people with severe disabilities had difficulties transferring work behaviors from sheltered workshops to community settings.[5] The combination of events described above with trends in special education and rehabilitation paved the way for the development of supported employment.[7]

Definition and Core Features

The most commonly used definition of supported employment is that of the Rehabilitation Act Amendments:

> **...competitive work in integrated work setting (a) for individuals with severe handicaps for whom competitive employment has not traditionally occurred, or (b) for individuals for whom competitive employment has been interrupted or intermittent as a result of a severe disability, and who, because of their handicap, need ongoing support services to perform such work. Such term includes transitional employment for individuals with chronic mental illness.**[1]

Supported employment is characterized by **four core features,** all of which must be present for a program to be considered supported employment. They are: (a) **competitive work**, (b) **integrated employment setting**, (c) **workers with severe disabilities**, and (d) **ongoing support.**[8]

Competitive Work:

Competitive work, as it applies to supported employment, "means work that is performed on a full-time basis or on a part-time basis, averaging at least 20 hours per week of each pay period, for which an individual is compensated in accordance with the Fair Labor Standards Act."[1]

Integrated Employment Setting:

Integration with persons without disabilities is a key component of supported employment. Various models of supported employment such as the individual placement model, dispersed enclaves, enclaves, and mobile work crew, have different amounts of integration. **In any model, no more than eight persons with disabilities can work in close proximity to each other.** Group models (e.g., mobile work crews, enclaves) are not as desirable as individual placements because they offer less opportunity for interaction with nonhandicapped peers, co-workers, and supervisory personnel.[8]

Severely Disabled Workers:

The Federal Register specifies that supported employment is a service for people with severe disabilities who otherwise would be unable to secure employment and remain competitively employed.[8] **To be considered eligible for supported employment programs receiving funding under the Rehabilitation Act Amendments, a person must have a "disability that seriously limits one or more functional capacities (mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of employability, and...can be expected to require multiple vocational rehabilitation services over an extended period of time...."[9]**

Ongoing Support:

A key element of supported employment is the ongoing support that is provided so the disabled can maintain employment. Supported employees must receive ongoing supportive services. Depending on the needs of the supported employee, such services may range from the continued presence of a job coach to job skill training services provided at least twice monthly at the work site.

Ecological Assessment

Supported employment requires an ecological approach to assessment. **The term ecological when used in this context refers to the underlying assumption that people interact with their environments and that both change as a result of the interaction.**[9] Ecological assessment is operationalized in two stages: general assessment and assessment of person-job congruence.[9]

General Assessment:

Two types of activities are included in general assessment: assessment of the individual and assessment of potential work environments.

Assessment of the individual. **Assessment of the individual involves integrating information from a variety of sources**, including school and rehabilitation facility records, interviews with the client and significant others, observation of the performance of job tasks in work settings, and limited use of standardized tests for population description and identification of service needs. Such information should assist in generation of hypotheses relating to the following questions:

1. **What are the person's vocational strengths and weaknesses?**
2. **What are the person's interests and aspirations?**
3. **What training techniques have been most or least successful with the person?**

4. **Has the person received any training in the past?** If so, what were the tasks and what prompts and/or reinforcers were used successfully?

5. **What types of work settings and job tasks are suitable and/or unsuitable for this person?**

6. **Has the person been in enough different work settings and done different job tasks to allow for knowledgeable participation in vocational planning? Is the person aware of different vocational options, and are those options viable?**

7. **What types of support will this person need in learning the job tasks and related social behaviors for this position?**

8. **What types of contributory support does the person need to adjust to employment (e.g., travel training, money skills, recreational skills, daily living skills)?**

9. **What types of accommodations or adaptations would enhance skill acquisition or performance?**[9]

Answers to those questions should provide the rehabilitation counselor with direction for the initial planning of potential jobs and suitable environments. **The answers, which form initial hypotheses, are refined or replaced as new information is learned.** In essence, ecological assessment is an ongoing process.[9]

Assessment of potential work environments. Detailed job analyses are used to gather information on potential jobs in the community. Such information is gathered by the rehabilitation counselor or by a job developer to assist with job matches for several persons. **Jobs are analyzed for skill requirements,** which include work skills, communication, and social skills.[9] The information obtained by general assessment of the person and job analysis provides the resources for assessment of person-job congruence.

Assessment of Person-Job Congruence:

Assessment of person-job congruence involves **two steps: (1) Identify potential job matches on the basis of comparison of job analyses with the needs and skills of specific persons;** and (2) **identify discrepancies between job/task requirements and individual characteristics and skill acquisition needs, and consider interventions or adaptations to resolve or reduce discrepancies.**

Identify potential job matches. **Person-job matches are identified by comparing information about the person with the job analyses.** Job modification and individual adaptation are options for resolution of potential incompatibilities.[9] **The following conditions need to be met before a match can be considered appropriate:**

1. The job must be **satisfactory** to the individual.
2. The job must be a **safe** one that will not harm the individual or others.
3. The individual's **work performance** (including interpersonal behaviors) **must be satisfactory to the employer.**
4. The job must **promote participation in and contribution to the community.**
5. **The job must not place undue stress** on family supports or limit social supports.
6. The job must **promote individual independence** and autonomy.[10]

Identify discrepancies between job/task requirements and individual characteristics. After potential job matches have been determined, the job analyses are more closely examined for discrepancies between the job requirements and the person's abilities. Job tasks that are likely to present obstacles to successful performance are examined through task analyses.[9] Cues that occur naturally and are associated with task performance are identified for each step. The resulting task analyses are compared with the individual abilities of the worker. Such comparisons, which are often accomplished through direct observation of the person performing the task, are used to identify discrepancies between the person's attributes and the requirements of the job and to determine interventions.[9]

Consider interventions to resolve or reduce discrepancies. There is a wide range of possible resolutions for discrepancies between individual characteristics and job requirements. Possible **resolutions include:** (a) **individual modifications** (e.g., change in appearance, learning compensatory skills), (b) **general job modifications** (e.g., job restructuring, flexible use of job coach support), and (c) **specific task modification** (e.g., cue highlighting [highlighting light switch with colored tape] or cue substitution [use of a verbal cue instead of an auditory cue] or mediation [use of verbal rehearsal strategies, checklists, or picture prompts]). The following principles should be used to guide the choice and use of resolutions:

1. **Interventions should be designed to be maximally under the control of the worker, not others.**
2. **Interventions should be designed to facilitate individual autonomy and independence.** Use of appropriate training techniques and support services encourages adaptability and independence.
3. **The least intrusive means that are still effective should be used.** Physical prompts, for example, should not be used when a checklist would suffice.

4. **The most natural interventions for a particular work environment should be used.** A pocket reminder list is more natural than a clipboard, and a break in work for early completion of a task is more appropriate than a star on a progress chart or edible reinforcer.[9]

Quality Components of Supported Employment

In discussing quality dimensions of supported employment, Szymanski, Hanley-Maxwell, and Parker[1] used **the input-process-output model** to focus on issues relevant to rehabilitation counseling practice. A condensed and updated version of their listing is presented in this section.

Input:

Input components of supported employment are community, individual, and agency **resources involved in the delivery of such services. Critical inputs for rehabilitation counselor consideration are consumers, staff, and job sites.**

Consumers. **Supported employment consumers are workers with severe disabilities.** Some persons currently receiving supported employment services may not need ongoing support. Patterson and Curl have suggested **placement of persons with mild disabilities into supported employment..."(a) constitutes as overly intrusive intervention, (b) creates unnecessary and unwarranted dependence, and (c) decreases the services available to persons with more severe disabilities."**[11] In evaluating the quality of supported employment programs, rehabilitation counselors should ask: Does the consumer have a severe disability? Does the consumer need ongoing support to remain employed?[1]

Staff. Considerable progress has been made in the areas of developing and implementing support strategies,[12] generalization and maintenance of work behaviors,[4] and teaching social skills on the job.[13] The staff, however, is the key ingredient to the actual implementation of these advances in supported employment practice. **In addition to staff *knowledge*, staff *attitudes* have also been found to be related to the success of supported employees.**[14] Currently, staff who are trained and/or knowledgeable in these areas are far too few in number. It is important to determine if the staff is trained in the necessary techniques and strategies and if staff members hold positive attitudes and expectations for consumers and consumers' work performance.[1]

Job sites. Quality issues related to job sites and job tasks include **diversity of work opportunities, culture of work environments, and integration with nondisabled co-workers.** Are there a diversity of job sites, and are supported employees placed in job sites according to their interests and skills? Rehabilitation counselors should be wary of programs that use a restricted variety of job sites.[1]

Process:

Process components are those **activities that define a supported employment program.** They include assessment, planning, training, problem solving, and monitoring/documentation.

Assessment. Supported employment interventions should be based on an ecological model of assessment as described in the previous section.[9] Standardized instruments, which have not been normed for the special populations for which they are being used, produce inadequate information.[15] To be meaningful, **assessment should involve observations of the client in multiple environments, performing a variety of tasks over time, while being instructed or supervised according to training strategies known to be effective.**[1] Rehabilitation counselors should consider the following quality questions in evaluating supported employment programs: **Is an ecological model used? Are multiple settings and tasks used? If possible, is the assessment longitudinal? Are the assessment instruments or techniques that are used valid for the population?**[1]

Planning. Supported employment involves **carefully matching individual needs and available employment opportunities** while providing **support to enable effective individual functioning.** Careful planning is critical. Rehabilitation counselors should, therefore, consider the following planning-related questions in judging the quality of supported employment programs.

1. Is there an individualized match between consumer and job, and is this match based on an analysis of person-environment congruence?
2. Is there coordination of – and longitudinal planning for – services with the focus on the needs and resources of the consumer, family, and employer?
3. Are there considerations of job modification and restructuring?
4. Are **funding sources and service providers** for ongoing support identified and assured?
5. Is there communication between all involved parties, including

a **written plan with specific responsibilities** (consumer, service providers, and family), **time frames, and criteria for evaluating successful performance?**

6. Is there **coordination between vocational planning and avocational planning and service delivery** (residential and recreational planning and services)?

7. Does planning emphasize the least intrusive service delivery to maximize independence, responsibility, and choice-making skills of consumers?[1]

Training. Training procedures are major determinants of successful supported employment outcomes. Effective training strategies are exceedingly important, as they promote the acquisition, generalization, and maintenance of work skills and behaviors.[1] Indicators of quality training in supported employment programs have suggested the following training-related questions for evaluation of supported employment programs.

1. **Is training individually determined according to written job and task analysis, and does it include job skills as well as social skills and other work-related behaviors?**

2. Does training occur **primarily at the job site, with supportive training provided at other locations as needed?**

3. Does training use **proven effective strategies** for the target population and involve planned generalizations and maintenance of work behaviors with cues and reinforcers identified as naturally occurring and used from the outset?

4. Is training **organized and systematic, with assistance gradually faded to assist in ensuring stable work performance?**

5. **Do trainers use effective and respectful communication with consumers?**[1]

Problem solving. Szymanski, Hanley-Maxwell, and Parker state that **the approach used by staff to assist with consumer performance and**

behavior problems is one of the best indicators of program quality.[1]

The following questions related to quality problem-solving approaches.

1. Are problems and solutions addressed from an ecological perspective, with attention to the environment, relevant interactions, and consumer behavior, or are problems addressed from a deficit orientation, which places the blame for the problem only with the consumer?

2. Are resolutions of problems based on a systematic and objective observation and recording of antecedents, behavior, and consequences?[1]

Monitoring/documentation. The behavioral training strategies used in supported employment rely on systematic monitoring and documentation for effective implementation. Therefore, rehabilitation counselors should consider the following questions in judging the quality of supported employment programs.

1. **Is service guided by written plans that include short- and long-term goals, behavioral objectives, measurement criteria, and staff responsibility for service delivery and training?**

2. **Is there careful, objective, written documentation of consumer work behavior that includes the level of independence on each task and type of prompts needed for task completion?**

3. **Is evaluation of consumer performance based on consumer goals and job and task analyses?**[1]

Output:

The components and activities from the Process and Input sections combine to produce program output.

Benefits to consumers, their families, employers, and communities are the primary output of quality supported employment services. Therefore, rehabilitation counselors should **consider the**

following quality indicators for supported employment outcomes.

1. **Are consumers and their families satisfied** with the job placement and supportive services?

2. **Are employers satisfied** with consumer work performance and agency support services?

3. Is there **job stability** for consumers?

4. **Do communities benefit** from workers with severe disabilities who are integrated throughout the workforce and who produce valued goods and services?[1]

Conclusion

This lesson has provided an overview of the factors that contribute to the development of supported employment, its core features, the meaning of ecological assessment, and quality dimensions. Supported employment provides an effective tool for rehabilitation counselors who wish to increase the employment options for persons with severe disabilities. As with any new tool, its ultimate value will depend on its proper use.

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QUESTIONS

45. Supported employment refers to:

A. Once a week psychotherapy session to support disabled clients who have assumed a place in the work force

B. A large fund of money, derived from corporate and governmental sources, to pay disabled employees for services regardless of the value of the work done to the community

C. Only providing methods of transportation for disabled workers to get to and from their place of employment

D. Planned programs to provide severely disabled individuals with competitive work in integrated work settings while receiving ongoing support of various kinds to facilitate this goal

46. Within the definition of supported employment, competitive work means:

A. A severely disabled individual must perform any given job as well as any nondisabled person without any special work supports

B. Work performed no less than 20 hours a week for which an individual is compensated in accordance with the Fair Labor Standards Act

C. Employment settings in which a minimum of 50 disabled individuals work together in close proximity to each other

D. Work requiring aggressive, outgoing behavior, such as sales

over, please...

47. In the effort to achieve person-job congruence:

A. The job need not be in any way satisfactory to the client

B. Safety considerations and stress factors are irrelevant

C. The job should be so secure and tightly supervised that the client cannot develop any independence or autonomy

D. Discrepancies may be resolvable by modifying the client's skills and behavior, adjusting the overall employment conditions, or using specific tactics to make tasks more manageable

48. Which of the following statements is/are correct?

A. Supportive employment programs should be heavily used by clients with very mild disabilities

B. Staff knowledge is vastly more important to the success of support employment than staff attitudes

C. Diversity of work opportunities, and integration with nondisabled workers are vital to the quality of supported employment efforts

D. All of the above

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